



**BlueCross BlueShield
of New Mexico**

New Mexico State University

Account #: 265001

A Guide To Your Group Preferred Provider (PPO) Health Care Plan

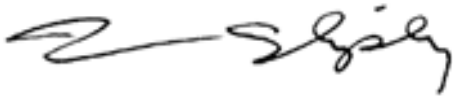


4-Tier Copayment Drug Plan Rider

for Large Group Coverages

This document provides information regarding the drug plan portion of the health benefits plan you have chosen. It is to be used in addition to the medical plan portion described in your Blue Cross and Blue Shield of New Mexico (BCBSNM) Member's Benefit Booklet. Please add this information to the *Covered Services* section of your current Benefit Booklet. For those terms not defined in this rider, please refer to your Benefit Booklet's Definitions section.

BY:



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Definitions

Brand-Name Drug — A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name Drug. There may also be situations where a drug's classification changes from Generic to Preferred or Nonpreferred Brand-Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Preferred or Nonpreferred Brand-Name.

Coinsurance — The **percentage** amount of a Covered Charge paid by you for certain items covered under this drug plan.

Copayment (or "Copoly") — The maximum fixed-dollar amount you pay for each covered prescription order filled or refilled for a covered supply purchased through a retail Pharmacy or designated mail-order service vendor under this drug plan.

Enteral Nutritional Product — A product designed to provide calories, protein, and essential micronutrients by the enteral route (i.e., by the gastrointestinal tract, which includes the stomach and small intestine only).

Generic Drug — A drug that has the same active ingredient as a Brand-Name Drug and is allowed to be produced after the Brand-Name Drug's patent has expired. In determining the brand or generic classification for covered drugs, BCBSNM uses the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of Generic Drugs is available on the BCBSNM website at www.bcbsnm.com. You may also contact a Customer Service Advocate for more information.

Genetic Inborn Errors of Metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

Legend Drugs — Drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution: Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

Nonpreferred Brand-Name Drug — A covered **non-specialty** Brand-Name Drug product or other item that is not identified on the *Drug List* as preferred and is subject to the Nonpreferred Brand Name Drug payment level.

Participating Pharmacy — A retail supplier that has contracted with BCBSNM or its authorized representative to dispense covered Prescription Drugs, Medicines and Devices, insulin, diabetic supplies, and nutritional products to Plan Members, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. Some Participating Pharmacies are contracted with BCBSNM to provide Specialty Drugs to Members; these Pharmacies are called “**Specialty Pharmacy providers**” and some drugs must be dispensed by these specially contracted providers in order to be covered.

Pharmacy — A state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any provider’s office, and where Legend Drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he or she practices.

Pharmacy Benefit Manager — An entity with which BCBSNM has entered into one or more agreements for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which BCBSNM is a party, including the health benefits plan to which this Drug Plan Rider is attached. (For more information, see section below entitled “*BCBSNM’s Separate Financial Arrangements with Pharmacy Benefit Managers.*”)

Preferred Brand-Name Drug — A covered **non-specialty** Brand-Name Drug product or other item that is identified on the *Drug List* and is subject to the Preferred Brand Name Drug tier payment level.

Prescription Drugs, Medicines, Devices — Those that are taken at the direction and under the supervision of a provider, that require a prescription before being dispensed, and are labeled as such on their packages. All Prescription Drugs, Medicines, and Devices must be approved by the FDA, and must not be experimental, investigational, or unproven. (See the “Experimental, Investigational, or Unproven Services” exclusion in your Benefit Booklet).

Special Medical Foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary food stuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special medical foods are covered only when prescribed by a physician for treatment of genetic errors of metabolism, and the Member is under the physician’s ongoing care. Special medical foods are not for use by the general public and may not be available in stores or supermarkets. Special medical foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Specialty Drugs — Prescription Drugs that: a) are high cost; b) are used in limited patient populations or indications; c) are typically self-injected; d) have limited availability, require special dispensing or delivery, and/or patient support is required and, therefore, are difficult to obtain via traditional Pharmacy channels; and/or e) require complex reimbursement procedures. These drugs must be purchased through the designated BCBSNM Specialty Pharmacy in order to be covered unless coverage is specifically provided elsewhere in this rider and/or is required by applicable law or regulation. Specialty Drugs, when covered, are subject to the applicable Tier 4 Copayment level, same as any other covered drug, according to the Tier structure of the drug plan noted in your Summary of Benefits (see “Member Copayments and Coinsurance” section of this rider).

Specialty Drug List — A list of the names of Specialty Drugs which must be purchased through BCBSNM’s Specialty Pharmacy provider. The *Specialty Drug List* is subject to periodic review and change by BCBSNM. If you need a list of Specialty Pharmacy drugs, request it from a Customer Service Advocate or visit the BCBSNM website at www.bcbsnm.com.

When you are being treated for an illness or accident, your doctor may prescribe certain drugs or other Pharmacy items as part of your treatment. Your coverage includes benefits for drugs that are self-administered and other items listed below. This rider explains which drugs and other items are covered and the benefits available for them under this drug plan portion of your health care benefits plan. The benefits of this rider are subject to all of the terms and conditions of your health benefits plan. For example, benefits will be provided only if drugs and supplies are Medically Necessary. Please see the *General Limitations and Exclusions* section of your Benefit Booklet for a full list of exclusions that apply to all health care services, including Prescription Drugs and other items under this rider.

All drugs listed on the Drug List or Specialty Drug List are covered unless specifically excluded. For example, if your health plan excludes weight management or obesity treatment, drugs for the treatment of obesity are also excluded. Prescription Drugs will not be excluded only because the drug has not been approved by the FDA for the treatment of your particular condition. Such a drug may be covered if it is recognized as safe and effective for the treatment of your condition in at least one standard medical reference compendium, including the “AMA Drug Evaluation,” the “American Hospital Formulary Service Drug Information,” and “Drug Information for the Healthcare Provider,” OR is being provided during a covered cancer clinical trial as required under NM state law. The drug will **not** be covered, however, if it is excluded for another reason (such as being for weight loss, cosmetic, etc.).

You, or your prescribing health care provider, can ask for a Drug List exception if your drug is not on the Drug List (also known as a formulary). To request this exception, you, or your prescriber, can call the number on the back of your ID card to ask for a review. If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, you, or your prescriber, may be able to ask for an expedited review process. BCBSNM will let you, and your prescriber, know the coverage decision within 24 hours after they receive your request for an expedited review. If the coverage request is denied, BCBSNM will let you and your prescriber know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Please refer to your benefit booklet for more information regarding the appeals process, or you can call the number on the back of your ID card if you have any questions.

Covered Medications and Other Items — The following drugs, supplies, and other products are covered only when dispensed by a Participating Pharmacy under the Retail Pharmacy or Specialty Pharmacy Drug Programs or when ordered through the designated Mail Order Service vendor:

- Prescription Drugs, prenatal vitamins, and medicines, unless listed as an exclusion (covered drugs/items include prescription contraceptive devices and medications purchased from a Participating Pharmacy (**Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from a physician, are payable under the “Family Planning” benefit, if any, of the medical portion of your health care benefits plan.)
- Specialty Drugs (such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex) (Most injectable drugs require **preauthorization** from BCBSNM. Some self-administered drugs, whether injectable or not, are identified as Specialty Drugs and must be acquired through BCBSNM’s designated Specialty Pharmacy provider in order to be covered.)
- vaccinations for flu or pneumonia, or Zostavax® vaccinations when received from certain Participating Pharmacies (For a list of Pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com.)
- insulin, glucagon, prescriptive oral agents for controlling blood sugar levels, and insulin needles, syringes, and other diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips). There is a separate Copayment for each item purchased. These items are **not** covered as a supply or medical equipment expense under the medical portion of your health care benefits plan. See “Supplies, Equipment, and Prosthetics” in your Benefit Booklet for a list of diabetic equipment that is covered under the medical portion of your health care benefits plan.**
- nonprescription enteral nutritional products and special medical foods only when either: 1) delivered through a Medically Necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of Special Medical Foods These products must be ordered by a physician and **preauthorization** received from BCBSNM in order to be covered.
- treatment with FDA-approved Prescription Drugs to assist you with quitting tobacco use or smoking**

** NOTE: For Members covered under **PPO** medical plans only, some of these items may also be purchased from an out-of-network Pharmacy. For details, see “Retail Pharmacy Program” below.

Preauthorization — Certain Prescription Drugs, injectable medications, and Specialty Pharmacy drugs may require preauthorization from BCBSNM. A list of drugs requiring preauthorization is on the BCBSNM website at www.bcbsnm.com. Your physician can request the necessary preauthorization.

Step Therapy — The step therapy program helps manage costs of expensive drugs by redirecting patients, when appropriate, to equally effective less expensive, generic alternatives. The program requires that Members starting a new drug treatment use Generic Drugs first when appropriate. Generic Drugs, which are tested and approved by the U.S. Food & Drug Administration (FDA), have been shown to be safe and effective. If the generic alternative is not effective, a Brand-Name Drug may then be acquired in the second step. You will be required to pay the applicable Copayment for Brand-Name Drugs. Although you may currently be on therapy, your request for non-Generic Drug alternatives may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the Brand-Name Drug.

Benefits for Orally Administered Anticancer Medications — Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. No Copayment amount will apply to orally administered anticancer medications listed on the Specialty Drug List. To determine if a specific drug is on the Specialty

Drug List, you may access the website at http://www.bcbsnm.com/member/specialty_rx.html or contact Customer Service at the toll-free number on your ID Card.

New-to-Market FDA Approved Drugs — New-to-Market FDA Approved Drugs are subject to review by Primes Therapeutics Pharmacy & Therapeutics (P&T) Committee prior to coverage of the drug.

Retail Pharmacy Program — Your drug plan provides access to the Pharmacies in the retail pharmacy network. All items covered under the Retail Pharmacy Program must be purchased from a Participating Pharmacy unless there is an Emergency (as defined in your Benefit Booklet). Also, for Members covered under a **PPO** medical plan, you may purchase the following items from an out-of-network Pharmacy and receive benefits as described later in this section: an orally administered anticancer medication, a Prescription Drug purchased for smoking cessation treatment, a diabetic drug or diabetic supply, or a drug covered as part of an approved in-state cancer clinical trial. (Claims for items purchased from a nonparticipating retail Pharmacy must be submitted to the Pharmacy Benefit Manager in order to be eligible for coverage under this drug plan.)

For a list of Participating Pharmacies, call Customer Service at the phone number on the back of your ID Card and request a provider directory — or visit the BCBSNM website at www.bcbsnm.com. The Pharmacies that are participating in the BCBSNM Retail Pharmacy Program may change from time to time. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status.

You must present your BCBSNM ID Card to the pharmacist at the time of purchase to receive this benefit. (You do not receive a separate prescription drug plan ID Card; use your BCBSNM health care plan ID Card to receive all medical/surgical and Prescription Drug services covered under your Plan, including this rider. Your drug plan Copayment amounts are listed on your Summary of Benefits and Coverage (SBC).) You are responsible for paying any such Copayments amounts noted in this rider for certain covered items, any pricing differences when applicable, or limited or non-covered services. No Claim forms are required when you purchase your prescriptions at a Participating Pharmacy.

NOTE: Specialty Drugs must be purchased from the BCBSNM-designated Specialty Pharmacy provider in order to be covered unless coverage is specifically provided elsewhere in this rider and/or is required by applicable law or regulation.

You can use your ID Card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under the medical portion of your health care benefits plan, the ID Card may not be used to purchase drugs or other items for the terminated member(s). If you do not have your ID Card with you or if you purchase your drug or other item from an out-of-network retail Pharmacy and it is eligible for coverage as indicated in the first paragraph of this Retail Pharmacy Program section, you must pay for the purchase in full and then submit a Claim directly to the BCBSNM Pharmacy Benefit Manager, Prime Therapeutics, at the address below (do not send to BCBSNM). If not included in your enrollment materials, you can obtain the necessary Claim forms from a Customer Service Advocate or on the BCBSNM website.

In such cases, you will be responsible for 50% of the Covered Charge (i.e., the BCBSNM-contracted rate) applicable had you purchased these covered items at a Participating Pharmacy, plus the tiered Copayment amount corresponding to these covered items under your particular drug plan. **However, no Copayment will apply to orally administered anticancer medications.** Drug plan benefits will be paid for the difference between the foregoing amounts that are your responsibility and any remaining Covered Charges up to the amount originally billed for these covered items by the out-of-network retail Pharmacy.

**Send Retail Pharmacy claims to:
Prime Therapeutics
PO Box 25136
Lehigh Valley, PA 18002-5136**

If you are leaving the country or need an extended supply of medication, call Customer Service at least **two weeks** before you intend to leave. (Extended supplies or vacation overrides are not available through the Mail Order Service but may be approved through the Retail Pharmacy Program only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.) Only up to one 90-day supply override may be allowed each Calendar Year.

Specialty Pharmacy Program — The specialty drug delivery service integrates Specialty Drug benefits with your overall medical and drug plan benefits. This program provides delivery of medications directly to your provider's office or to your home if you are undergoing treatment for a complex medical condition. The Specialty Pharmacy Program delivery service offers:

- coordination of coverage among you, your health care provider, and BCBSNM
- educational materials about your condition and information about managing possible medication side effects
- syringes, sharps containers, alcohol swabs, and other supplies with every shipment of FDA-approved self-injectable medications

- access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days a year

Except as provided elsewhere in this rider for orally administered anticancer medications for Members covered under a **PPO** medical plan or as otherwise required under applicable law or regulation, this drug plan covers only those Specialty Drugs that are listed on the *Specialty Drug List*. The *Specialty Drug List* is on the BCBSNM website at <https://www.bcbsnm.com/member/prescription-drug-plan-information/drug-lists> or can be obtained from a Customer Service Advocate by calling the phone number on the back of your ID Card. Your cost for Specialty Drugs is indicated under the “Member Copayments” section below and you will be responsible for any Copayments, any pricing differences when applicable, noncovered Specialty Drugs, and other limited or non-covered services that may apply to your coverage.

Mail Order Service — Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service Advocate.) **Note:** Prescription Drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved through the Retail Pharmacy Program only.

IMPORTANT: Specialty Drugs are not covered through the Mail Order Service. You must use the Specialty Pharmacy provider designated by BCBSNM in order to receive benefits for Specialty Drugs.

Member Copayments and Coinsurance — For covered Prescription Drugs, insulin, diabetic supplies, and nutritional products, you pay the applicable tiered Copayment or applicable Coinsurance (see below), not to exceed the actual retail price, for each prescription filled or item purchased (not to exceed supply limitations described below). **See your Summary of Benefits for your Copayment and Coinsurance amounts. Any Copayment and Coinsurance amounts due for certain covered items are noted in this rider.**

Each Calendar Year, the Copayments and Coinsurance percentage amounts, are applied to your or your family’s applicable annual prescription drug out-of-pocket limit for that Calendar Year. Any pricing differences between the cost of Brand Name Drugs and their generic equivalents that you pay under this drug plan portion of your health care benefits plan are not applied to your or your family’s applicable annual prescription drug out-of-pocket limit for that Calendar Year under the medical portion of your health care benefits plan (*see your SBC*). After you have met this prescription drug out-of-pocket limit during a single Calendar Year, BCBSNM pays 100% of your covered prescription drugs, insulin, diabetic supplies, and nutritional products under this drug plan for the remainder of that Calendar Year.

Your drug plan offers several benefit design Copayment options for when you purchase drugs or supplies from a Participating Pharmacy or a BCBSNM-designated Specialty Pharmacy provider, or BCBSNM-designated Mail Order Service vendor (see below for an example of a 4-Tier Copayment Drug Plan and how it works). When you need a prescription order filled, you should use a Participating Pharmacy. Each prescription or refill is subject to the Copayment or Coinsurance shown on the SBC.

When you go to a Participating Pharmacy, you must pay any Copayment, Coinsurance and any applicable pricing differences. You may be required to pay for limited or noncovered services. No claim forms are required. If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the website at http://www.bcbsnm.com/provider_finder/important_information_rx.html or contact Customer Service at the toll-free number on your ID Card.

How Member Payment is Determined. Prescription drug products are separated into tiers. Generally, each drug is placed into one of four drug tiers:

- **Tier 1** includes mostly Generic Drugs and may contain some Brand Name Drugs.
- **Tier 2** includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
- **Tier 3** includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.
- **Tier 4** includes mostly Specialty Drugs and may contain some Generic Drugs.

To verify your payment amount for a drug, visit <https://www.bcbsnm.com> and log into Blue Access for Members or call the number on the back of your ID card. *Benefits will be provided as shown on the Summary of Benefits and Coverage (SBC) of this policy.*

For additional information, please refer to the Outpatient Prescription Drug section as shown in the *Summary of Benefits and Coverage (SBC)* of this policy.

See your Summary of Benefits for the drug plan Copayment and Coinsurance option that corresponds to the health benefits plan you have chosen.

For example, if the health benefits plan you chose features this option: \$15/30%/40%/25%		
Four-Tier Plan		
Generic	Tier 1	Charge \$15 Copay
Preferred Brand-Name	Tier 2	Charge 30% up to \$30 min/\$50 max Copay
Nonpreferred Brand Name (no generic equivalent)	Tier 3	Charge 40% up to \$50 min/\$85 max Copay
Specialty (no generic equivalent)	Tier 4	Charge 25% up to \$130 min/\$275 max Copay
For all Brand-Name Drug with an FDA-approved generic equivalent, if you or your provider order the brand-name, you will pay the Coinsurance PLUS the difference in cost between the Brand-Name Drug and its generic equivalent.		
Select vaccinations for flu or pneumonia, or Zostavax received from certain Participating Pharmacies . For a list of covered vaccinations see your Drug List https://www.bcbsnm.com/member/prescription-drug-plan/information/drug-lists For a list of Pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at https://www.bcbsnm.com/provider_finder/important_info_rx.html	No Copay or Coinsurance	
Mail Order Service (available for Tiers 1, 2 and 3 only; Specialty Drugs are not covered through Mail Order Service)	Copay or Coinsurance for Tier 1, 2 or 3 drug — depending on generic/brand and Drug List status	
Nonprescription Enteral Nutritional Products and Special Medical Foods (requires preauthorization)	Coinsurance of 50% of Covered Charges	

Except as may be specified elsewhere in this rider, drugs and supplies must be purchased from a Participating Pharmacy, or a BCBSNM-designated Specialty Pharmacy provider, or BCBSNM-designated Mail Order Service vendor in order to be covered under your drug plan.

Supply Limitations — For each Copayment listed for your drug plan, you can obtain the following supply of a single Prescription Drug or other item covered under this rider (unless otherwise specified):

Program Type	Supply Maximum	Copayment or Coinsurance Requirements
Nonprescription Nutritional Products	30-day supply during any 30-day period	Coinsurance of 50% of Covered Charges (includes prescriptions for enteral nutritional products and special medical foods as described under “Covered Drugs and Other Items”)
Retail Pharmacy and Specialty Pharmacy Provider	During each one-month period, a 30-day supply (e.g., pills)	One Copayment. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days).
Mail Order Service (Tiers 1, 2, and 3 only)	During each three-month period, a 90-day supply (e.g., pills)	2 Copayments

Dispensing Limits — In addition to the supply limits stated above and regardless of the quantity of a covered drug prescribed by a physician, BCBSNM has the right to establish dispensing limits on covered drugs. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, identify gender or age restrictions, and/or the maximum quantity of a drug (or member of a drug class) that can be dispensed to you over a specific period of time. Such limits are in place to encourage appropriate drug use and patient safety, and to reduce waste and stockpiling of drugs. Benefits for a covered drug may also be denied if the drug is dispensed or delivered in a manner intended to avoid the BCBSNM-established dispensing limit. If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to BCBSNM on your behalf. The preauthorization request will be approved or denied after the clinical information submitted by the prescribing doctor has been evaluated by BCBSNM.

Controlled Substances — If it is determined that a member may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, benefits may be subject to a review to determine medical necessity, appropriateness and other restrictions which may include but not limited to services provided by a certain provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication. Additional Copayments/Coinsurance and any Deductible may apply. For the purposes of this provision, controlled substance medications are medications restricted by state or federal laws because of their potential of addiction or misuse.

Drug Plan Exclusions — In addition to services listed as not eligible for coverage in the *General Limitations and Exclusions* section of your medical plan portion's Benefit Booklet, this drug plan portion of your health benefits plan does **not** cover:

- brand Proton Pump Inhibitors (PPI)
- Prescription Drugs if there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan, at its sole discretion
- herbal or homeopathic preparations
- drugs which by law do not require a prescription order from an authorized health care practitioner (except insulin, insulin analogs, insulin pens, oral agents for controlling blood sugar level, and vaccinations administered through certain Participating Pharmacies)
- Legend Drugs or covered devices for which no valid prescription order is obtained
- non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration- approved indications provided by the ingredients' manufacturers.
- prescriptions or other covered items purchased from a non-Participating Pharmacy provider or other provider unless eligible for benefits in an Emergency situation (as defined in your Benefit Booklet) or for Members covered under PPO medical plans, as listed under "Retail Pharmacy Program," and purchased from a non-Participating retail Pharmacy
- refills before the normal period of use has expired, in excess of the number specified by the physician, or requested more than one year following the physician's original order date (Some prescriptions may be subject to a shorter refill window. Please call customer service for details.)
- replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced
- infertility medications
- nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or Prescription Drugs that have over-the-counter equivalents
- drugs or other items for the treatment of sexual or erectile dysfunction
- devices or durable medical equipment of any type (even though such devices may require a prescription order) such as, but not limited to, therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics)
- Tretinoin (sold under such brand names as Retin-A) for cosmetic purposes if you are age 40 or above
- nonprescription enteral nutritional products that are taken by mouth or delivered through a temporary nasogastric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for genetic inborn errors of metabolism and the product is **preauthorized** by BCBSNM); or nonprescription nutritional products that have not been preauthorized by BCBSNM
- Prescription Drugs in a drug class where there is an over-the-counter alternative available
- drugs that are repackaged by a company other than the original manufacturer

- shipping, handling, or delivery charges
- appetite suppressants or diet aids; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes
- ordinary foodstuffs that might be part of an exclusionary diet; any product that does not have and/or require a physician's prescription; food items purchased at a health food, vitamin or similar store; foods purchased on the Internet
- drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives
- covered drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under Workers' Compensation law
- drugs obtained by unauthorized, fraudulent, abusive, or improper use of an identification card
- drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the medical portion of health care benefits plan, or for which benefits have been exhausted
- any Prescription Drug for which the FDA has determined its use to be contraindicated for the treatment of the particular condition for which the drug has been prescribed
- any drugs which are not approved by the FDA for a particular diagnosis or indication, or when used for an indication other than the indication for which the FDA approval is given, except when: **a)** recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American hospital formulary service drug information," and "drug information for the healthcare provider;" **b)** when provided for cancer clinical trials, pursuant to Section 59A-22-43 NMSA; or **c)** as otherwise required under applicable law or regulation
- Devices and Pharmaceutical Aids
- Institutional packs
- Surgical Supplies
- Ostomy Products
- Diagnostic Agents, except diabetic test strips
- General Anesthetics
- Bulk Powders
- Drugs that are not considered medically necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Any self-administered drugs dispensed by a Physician

Drug Exclusions - Some equivalent drugs are manufactured under multiple brand names. Generic medications may also have several therapeutic equivalents. In some cases, the Plan may limit Benefits to only one of the equivalents available. If you do not accept the therapeutic equivalents that are covered under your Prescription Drug program, the drug purchased will not be covered under any Benefit level.

Note: Prescription contraceptive devices are payable under the medical portion of your health benefits plan. Please see your Benefit Booklet's "Family Planning" provision under the "Covered Services" section.

BCBSNM'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

Blue Cross and Blue Shield of New Mexico (BCBSNM) hereby informs you that it has contracts, either directly or indirectly, with participating prescription drug providers for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies, and contracts to which BCBSNM is a party, including this contract. Pursuant to BCBSNM's contracts with participating prescription drug providers, under certain circumstances described therein, BCBSNM may receive discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescription drugs will vary. Some discounts are currently based on Average Wholesale Price (AWP) which is determined by a third party and is subject to change.

BCBSNM may receive such discounts, although you are not entitled to receive any portion of any such discounts. The drug fees and/or discounts that BCBSNM has negotiated with Prime Therapeutics LLC (Prime) through the Pharmacy Benefit Management (PBM) Agreement will be used to calculate your share of the cost of prescription drugs for retail and mail/specialty drugs. Except for mail and/or specialty drugs, the PBM Agreement requires that the fees and/or discounts that Prime has negotiated with pharmacies (or other suppliers) are passed on to BCBSNM (and ultimately to you as described above).

To help you understand how BCBSNM's separate financial arrangements with participating prescription drug providers work, please consider the following example:

Assume you have a prescription dispensed and the undiscounted amount of the prescription drug is \$100. How is the \$100 bill paid?

- You will have to pay the Copayment amount set out in this Contract.
- For purposes of calculating your Copayment amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the \$100 prescription drug bill would be reduced by 20% to \$80 for purposes of calculating your Copayment amount.
- In our example, if your Coinsurance obligation is 5%, you will have to pay 5% of \$80, or \$4. You should note that your 5% Coinsurance amount is based upon the discounted amount of the prescription and not the full \$100 bill.

For the mail and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail and/or specialty pharmacy program. BCBSNM pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail-order processing.

"Weighted paid claim" refers to the methodology of counting claims for purposes of determining BCBSNM's fee payment to Prime. Each retail paid claim equals one weighted paid claim (including claims dispensed through the PBM's specialty pharmacy program); each extended supply or mail order (including Mail Service) paid claim equals three weighted paid claims. However, BCBSNM pays Prime a Program Management Fee ("PMF") on a per paid claim basis. "Funding Levers" means a mechanism through which BCBSNM funds the fees (net fee, ancillary fees and special project fees) owed to the PBM. Funding levers always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction fees, and, if elected by BCBSNM, may include rebates and retail spread. BCBSNM's net fee owed to Prime for core services will be offset by the Funding Levers. BCBSNM pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per weighted paid claim.

The amounts received by Prime from BCBSNM, pharmacies, manufacturers, or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to BCBSNM, administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Contract. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given Calendar Year to members of BCBSNM and other Blue Plan operating divisions.

BCBSNM'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

BCBSNM hereby informs you that it owns a significant portion of the equity of Prime and that BCBSNM has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers," or "PBMs"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which BCBSNM is a party, including this Contract. PBMs have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of BCBSNM, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). BCBSNM may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

CUSTOMER ASSISTANCE

Customer Service:—The 24/7 Nurseline can help when you have a **health** problem or concern. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week.

24/7 Nurseline toll-free telephone number: 1-800-973-6329

When you have a **non-medical** benefit question or concern, call BCBSNM Monday through Friday from 6 A.M. - 8 P.M. and 8 A.M. - 5 P.M. on Saturdays and most holidays or visit the BCBSNM Customer Service department in Albuquerque. (If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 P.M. the next business day.) You may either call toll-free or visit the BCBSNM office in Albuquerque at:

NMSU Designated Service Unit (DSU)
1-866-369-NMSU (6678)
Street address: 4373 Alexander Blvd. NE

Send all **written inquiries/preauthorization requests** and submit **medical/surgical claims*** to:

Blue Cross and Blue Shield of New Mexico Attn:NMSU
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Preauthorizations: Medical/Surgical Services and Prescription Drugs—For preauthorization requests, call a Health Services representative, Monday through Friday 8 A.M. - 5 P.M., Mountain Time. Written requests should be sent to the address given above. **Note:** If you need preauthorization assistance between 5 P.M. and 8 A.M. or on weekends, call Customer Service. If you call after normal Customer Service hours, you will be asked to leave a message.

1-505-291-3585 or 1-800-325-8334

Mental Health and Chemical Dependency—For inquiries or preauthorizations related to mental health or chemical dependency services, call the Behavioral Health Unit (BHU):

24 hours/day, 7 days/week: 1-888-898-0070

Send claims* to:

Claims, Behavioral Health Unit
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Website—For provider network information, BCBSNM Drug List, claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM website at:

www.bcbsnm.com

***Exceptions to Claim Submission Procedures**—Claims for health care services received from providers that do not contract **directly** with BCBSNM, should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. **Note: Do not submit drug plan claims to BCBSNM.** See *Section 8: Claim Payments and Appeals* for details on submitting claims.

A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

Welcome to the New Mexico State University (NMSU) PPO Plan for eligible retirees. This Plan is underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in health care. Like most people, you probably have many questions about your coverage. This benefit booklet contains a great deal of information about the services and supplies for which benefits will be provided under your Plan. Please read your entire benefit booklet very carefully. We hope that most of the questions you have about your coverage will be answered.

We refer to our company as “BCBSNM” in this benefit booklet, and we refer to the company (or as a retiree of NMSU) as the “group.” *Section 10: Definitions* will explain the meaning of many of the terms used in this benefit booklet. Whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under this Plan.

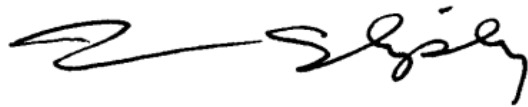
Please take some time to get to know your health care benefit plan coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. Learning how this plan works can help make the best use of your health care benefits.

BCBSNM and your group may change the benefits described in this benefit booklet. If that happens, BCBSNM or your group will notify you of those mutually agreed upon changes.

If you have any questions once you have read this benefit booklet, talk to your benefits administrator or call us at the number listed on the back of your ID card, or as listed in *Customer Assistance* on the inside front cover. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield of New Mexico! We are very happy to have you as a member and pledge you our best service.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kurt Shipley', written in a cursive style.

Kurt Shipley
President, Blue Cross and Blue Shield of New Mexico

New Mexico State University reserves the right to increase, decrease, or discontinue any or all provisions under the NMSU Health Care Plan. Any modifications to the Plan will apply to all covered persons, including retirees, who are covered under the Plan at the time of such change.

Feel free to contact Benefit Services at (575) 646-8000 with any questions you may have regarding benefits.

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This benefit booklet describes the medical/surgical, prescription drug, and mental health/chemical dependency coverage available to members of this Managed Care Medical Plan and the Plan's benefit limitations and exclusions.

- Always carry your current Plan ID card issued by BCBSNM. When you arrive at the provider's office or at the hospital, show the receptionist your Plan ID card. You may be required to pay copayments or other estimated amounts due at the time of your visit.
- To find doctors and hospitals nearby, you may use the Internet, make a phone call, or request a hard copy of a directory from BCBSNM. See details in *Section 3: How Your Plan Works*.
- Call BCBSNM (or the Behavioral Health Unit) for preauthorization, if necessary. The phone numbers are on your Plan ID card. See *Section 4: Preauthorizations* for details about the preauthorization process.
- Please read this benefit booklet and familiarize yourself with the details of your Plan *before* you need services. Doing so could save you time and money.
- **In an emergency, call 911 or go directly to the nearest hospital.**

DEFINITIONS

Throughout this benefit booklet, many words are used that have a specific meaning when applied to your health care coverage. When you come across these terms while reading this benefit booklet, please refer to *Section 10: Definitions*, for an explanation of the limitations or special conditions that may apply to your benefits.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

The Summary of Benefits and Coverage is referred to as the *Summary of Benefits* throughout this benefit booklet. The *Summary of Benefits* shows the specific member cost-sharing amounts and coverage limitations of your Plan. If you do not have a *Summary of Benefits*, please contact a BCBSNM Customer Service Advocate (the phone number is at the bottom of each page of this benefit booklet). You will receive a new *Summary of Benefits* if changes are made to your health care plan.

IDENTIFICATION (ID) CARD

You will receive a BCBSNM identification (ID) card. The ID card contains your "group" number and your identification number (including an alpha prefix) and tells providers that you are entitled to benefits under this health care plan with BCBSNM.

Carry it with you. Do not let anyone who is not named in your coverage use your card to receive benefits. If you need an additional card or need to replace a lost card, contact a BCBSNM Customer Service Advocate.

PROVIDER NETWORK DIRECTORY

The provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all providers and their qualifications in the BCBSNM Preferred Provider (PPO) network and participating pharmacies. It also provides links to the listings of Preferred Providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service. It will be mailed to you free of charge.) **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider's status or if you have any questions about the directory, contact a Customer Service Advocate or visit the BCBSNM website.

DRUG PLAN BENEFITS

BCBSNM has contracted with a separate pharmacy benefit manager to administer your outpatient drug plan benefits. In addition to your benefit booklet, you will be sent important information about your drug plan benefits. See your separately issued *Drug Plan Rider* for more information about the drug plan.

BLUECARD® BROCHURE

As a member of a PPO health plan administered by BCBSNM, you take your health plan benefits with you – across the country and around the world. The BlueCard Program gives you access to Preferred Providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your Eligible Family Members can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care providers that contract as Preferred Providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It's a valuable addition to your health care plan coverage. Instructions for locating a Preferred Provider outside New Mexico are in the brochure or can be found on the BCBSNM website at www.bcbsnm.com.

LIMITATIONS AND EXCLUSIONS

Each provision in *Section 5: Covered Services* not only describes what is covered, but may list some limitations and exclusions that specifically relate to a particular type of service. *Section 6: General Limitations and Exclusions* lists limitations and exclusions that apply to *all* services.

PREFERRED PROVIDER BENEFIT ONLY

Some services are eligible for benefits **only** when received from Preferred Providers. Refer to your *Summary of Benefits* for specific details.

- transplant and transplant-related services (Services must be received at a facility that contracts with BCBSNM, the local BCBS Plan, or the national BCBS transplant network, for the transplant being provided.)
- outpatient cardiac and pulmonary rehabilitation
- physical, occupational and speech therapy
- spinal manipulation
- acupuncture
- skilled nursing facility services
- preventive services
- smoking/tobacco use cessation counseling

PREAUTHORIZATION REQUIRED

To receive full benefits for some non-emergency admissions and certain medical/surgical services, you or your provider must call the BCBSNM Health Services department **before** you receive treatment. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. See *Section 4: Preauthorizations* for details. **Note:** Call Customer Service if you need preauthorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

To receive full benefits for emergency hospital admissions, you (or your provider) should notify BCBSNM **within 48 hours** of admission, or as soon as reasonably possible following admission. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. Also, if you have a routine delivery and stay in the hospital **more than 48 hours**, or if you have a C-section delivery and stay in the hospital **more than 96 hours**, you must call BCBSNM for preauthorization before you are discharged.

Written Request Required

If a **written request** for preauthorization is required in order for a service to be covered, you or your provider should send the request, along with appropriate documentation, to:

Blue Cross and Blue Shield of New Mexico
Attn: Health Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630

Please ask your health care provider to submit your request early enough to ensure that there is time to process the request before the date you are planning to receive services.

PREAUTHORIZATION OF BEHAVIORAL HEALTH CARE

All inpatient and specified outpatient mental health and chemical dependency services must be preauthorized by the Behavioral Health Unit (BHU) at the phone number below (also listed on the back of your ID card). For services requiring preauthorization, you or your physician should call the BHU before you schedule treatment. The BHU will coordinate covered services with an in-network provider near you. **If you do not call and receive preauthorization before receiving non-emergency services, benefits for services may be denied.** Call 7 days a week, 24 hours a day:

Toll-Free Phone Number: 1-888-898-0070

HEALTH AND WELLNESS MAINTENANCE AND IMPROVEMENT PROGRAMS

BCBSNM and your employer have the right to offer programs for the purposes of medical management programs, quality improvement programs, and health behavior wellness, maintenance or improvement over and above the standard benefits provided by this Plan. These programs may allow for a reward, a contribution, a disincentive, a differential in premiums or a differential in medical, prescription drug or equipment Copayments, Coinsurance, Deductibles or costs, or a combination of incentives and/or disincentives for participation in any program offered or administered by BCBSNM or any retailer, Provider, or manufacturer chosen by BCBSNM to administer such program. Discount programs for various health behavior wellness or insurance-related items and services may also be available from time to time. For details of current discounts or other programs available, please contact a Customer Service representative by calling the phone number on the back of your ID card. Such programs may be discontinued with or without notice. Contact your employer for additional information regarding any value based programs offered by your employer.

For individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse status and unless otherwise permitted by law. Blue Cross Blue Shield will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact Blue Cross Blue Shield for additional information regarding any value based programs offered by Blue Cross Blue Shield.

VIRTUAL VISITS

Covered Services provided via consultation with a licensed Provider through interactive video via online portal or mobile application. Virtual Visits provide access to Providers who can provide diagnosis and treatment of non-Emergency medical and Mental Illness conditions in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit.

Virtual Visits Member cost share will be the same as an in-person primary care office visit and for Behavioral health Virtual Visits, Member cost share is the same as a behavioral health office visit in-person.

IDENTITY THEFT PROTECTION SERVICES

As a Member, BCBSNM makes available at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSNM's designated outside vendor and acceptance or declination of these services is optional to Member. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsnm.com or telephonically by calling the toll free telephone number on your identification card. Services may automatically end when the person is no longer an eligible Member. Services may change or be discontinued at any time with or without notice and BCBSNM does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

DESIGNATED CUSTOMER SERVICE

If you have any questions about your coverage, call or e-mail BCBSNM's dedicated New Mexico State University Designed Customer Service Unit (DSU). Customer Service Advocates are available Monday through Friday from 6 A.M. – 8 P.M. and 8 A.M. – 5 P.M., Mountain Standard Time on Saturdays and most holidays. If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 P.M. the next business day.

Customer Service representatives can help with the following:

- answer questions about your benefits
- assist with preauthorization requests
- check on a claim's status
- help you change your PCP selection
- order a replacement ID card, provider directory, benefit booklet, or forms

For your convenience, the toll-free customer service number is printed at the bottom of every page in this benefit booklet. Refer to Customer Assistance on the inside cover of this booklet for important phone numbers, website, and mailing information. You can also e-mail the Customer Service unit via the BCBSNM website noted below:

In addition to accepting e-mail inquiries, the BCBSNM website contains valuable information about BCBSNM provider networks, the BCBSNM Drug List, and other Plan benefits. It also has various forms you can print off that could save you time when you need to file a claim.

Website: www.bcbsnm.com

Behavioral Health Customer Service

When you have questions about your behavioral health benefits, call the BCBSNM Behavioral Health Unit (BHU) for assistance.

Toll-free: 1-888-898-0070

Deaf and Speech Disabled Assistance

Deaf, hard-of-hearing, and speech disabled callers may use the New Mexico Relay Network. Dialing **711** connects the caller to the state transfer relay service for TTY and voice calls.

Translation Assistance

If you need help communicating with BCBSNM, BCBSNM offers Spanish bilingual interpreters for members who call Customer Service. If you need multilingual services, call the Customer Service phone number on the back of your ID card.

After Hours Help

If you need or want help to file a complaint outside normal business hours, you may call Customer Service. Your call will be answered by an automatic phone system. You can use the system to:

- leave a message for BCBSNM to call you back on the next business day
- leave a message saying you have a complaint or appeal
- talk to a nurse at the 24/7 Nurseline right away if you have a health problem

24/7 Nurseline

If you can't reach your doctor, the free 24/7 Nurseline will connect you with a nurse who can help you decide if you need to go to the emergency room or urgent care center, or if you should make an appointment with your doctor. The Nurseline will also give you advice if you call your doctor and he or she can't see you right away when you think you might have an urgent problem. To learn more, call:

Toll-free: 1-800-973-6329

BCBSNM also has a phone library of more than 1000 health topics available through the Nurseline, including over 600 topics available in Spanish.

Special Beginnings

This is a maternity program that helps you better understand and manage your pregnancy. You should enroll in the program within three months of becoming pregnant, by calling:

Toll-free: 1-888-421-7781

BLUE ACCESS FOR MEMBERSSM

To help members track claim payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan members. The online “Blue Access for Members” (BAM) tool provides convenient and secure access to claim information and account management features and the Cost Estimator tool. While online, members can also access a wide range of health and wellness programs and tools, including a health assessment and personalized health updates. To access these online programs, go to www.bcbsnm.com, log into Blue Access for Members and create a user ID and password for instant and secure access.

If you need help accessing the BAM site, call:

BAM Help Desk (toll-free): 1-888-706-0583

**Help Desk Hours: Monday through Friday 6 A.M. – 9 P.M., Mountain Standard Time
Saturday 6 A.M. – 2:30 P.M. Mountain Standard Time**

Note: Depending on your group’s coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM uses data about program usage and member feedback to make changes to online tools as needed. Therefore, programs and their rules are updated, added, or terminated, and may change without notice as new programs are designed and/or as our members’ needs change. We encourage you to enroll in BAM and check the online features available to you – and check back in as frequently as you like. BCBSNM is always looking for ways to add value to your health care plan and hope you will find the website helpful.

ENROLLMENT ASSISTANCE

If you need assistance enrolling, changing an address, terminating coverage, or changing coverage, or if you have any questions regarding eligibility in your group Plan, contact NMSU Benefit Services:

New Mexico State University
Attn: Benefit Services
Off-site: P.O. Box 30001, MSC 3HRS, Las Cruces, NM 88003-8001
Telephone: (575) 646-8000

HEALTH CARE FRAUD INFORMATION

Health care and insurance fraud results in cost increases for health care plans. You can help; always:

- Be wary of offers to waive copayments, deductibles, or coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your providers and the *Explanation of Benefits* (EOB) you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call a BCBSNM Customer Service Advocate.
- Be very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact the BCBSNM Fraud Hotline at 1-888-841-7998.

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

ENROLLMENT ASSISTANCE

You are responsible for advising the appropriate party of any address change, any change that may affect you or a family member's eligibility, and of any changes to a covered family member's name. You are also responsible for requesting changes to your coverage by submitting signed and completed enrollment/change forms to the appropriate party. Your contact for billing and premium, enrollment, eligibility and termination assistance depends upon whether you are covered under the regular group plan coverage, or a federal continuation coverage due to COBRA:

Regular Group Coverage - NMSU is responsible for all administrative policies regarding premium deduction or premium collection for members covered under the group plan. Note: COBRA premiums are collected by Health Care Service Corporation (HCSC). If you need assistance enrolling, changing an address, terminating coverage, or changing coverage, or if you have any questions regarding eligibility in the group plan or your premiums for group coverage, contact:

New Mexico State University
Attn: Benefit Services
P.O. Box 30001, MSC 3HRS, Las Cruces, NM 88003-8001
Telephone: (575) 646-8000

COBRA Continuation Coverage - Members covered under a federal continuation plan due to COBRA should direct questions to:

Health Care Service Corporation
P.O. Box 2387
Danville, IL 61834-2384
Telephone (888) 541-7107

Premiums for federal continuation coverage should be mailed to:

Health Care Service Corporation
21806 Network Place
Chicago, IL 60673-1218

WHO IS ELIGIBLE

The Plan covers only those retirees and their eligible family member who are under age 65 and not entitled to Medicare. Exception: Members who are entitled to Medicare due to end-stage renal disease may continue coverage in this Plan for the period during which Medicare is secondary to Plan coverage according to federal regulation. After this coordination time period is exhausted, the member must switch to the NMSU Medigap Plan G.

Retiree - An employee who officially retires from New Mexico State University and receives a benefit from the New Mexico Educational Retirement Board (NMERB) or New Mexico Alternative Retirement Plan (NMARP) immediately upon termination of employment may receive health insurance benefits after retirement if the retiree was enrolled in the NMSU employee health plan for ten consecutive years in regular status immediately prior to retirement. (Persons eligible under the NMARP must immediately begin receiving a benefit, and have been enrolled in the NMSU employee health plan for ten consecutive years in regular status immediately prior to retirement.) The ten years of coverage must, at a minimum, be satisfied as of the month in which the employee retires from the university. Time enrolled as a regular employee (or as the spouse/qualified domestic partner of an active, regular employee if both you and your spouse/qualified domestic partner are employed by NMSU) will be counted toward the ten-year requirement.

If a retiree becomes re-employed by NMSU in a benefit eligible employment status, the retiree may maintain NMSU employee health insurance coverage during the re-employment period. The retiree/employee will meet the eligibility requirements under this Plan to re-enroll on the retiree health plan upon leaving employment provided the following conditions are met:

- the retiree/employee maintains continuous health insurance coverage with NMSU from retirement to employment to re-retirement (minus any applicable waiting periods); and
- the retiree/employee re-retires and immediately begins collecting retirement benefits from the ERB or ARP upon re-retirement, if benefits were suspended upon hire.

Spouses or Domestic Partners – Spouses or domestic partners of eligible retirees covered at the time of retirement may continue coverage after the employee’s retirement. Retirees may also add coverage for spouses or domestic partners acquired after retirement. See “[Adding Eligible Family Members Adding A Family Member To Coverage](#)” for more information.

Children – Only those eligible children who were covered at the time of retirement may continue coverage after the employee retires. Eligible children acquired after retirement may not be added at a later date, except as specified under “[Adding Eligible Family Members Adding A Family Member To Coverage](#)”. Surviving eligible family member contract holders may not add new family members to coverage at any time.

Medicare-Eligible Retirees and Retirees Eligible Family Members – Except during the limited period of time in which this Plan is primary over Medicare due to federal regulations regarding coverage for patients with end-stage renal disease, retirees and/or their eligible family members who are enrolled in Part A and Part B of Medicare may not enroll in this NMSU PPO Plan and may not continue coverage in this Plan after becoming eligible for Medicare. In such cases, the member with Parts A and B of Medicare will be required to switch to the NMSU Medigap Plan G. Members who are enrolled in only one Part of Medicare are not eligible for coverage under any NMSU retiree health plan.

For example, a retiree’s eligible family member who has Medicare due to end-stage renal disease is primary under this Plan for only 30 months following the date of his/her first dialysis treatment. The eligible family member would switch to the NMSU Medigap Plan G after the 30-month period.

Eligible retirees and their eligible family members (including eligible survivor family members) who are under age 65 and not enrolled in Medicare may continue coverage in this NMSU PPO Plan.

Coverage After Retirement – Employees hired after July 1, 2016 are not eligible for the retiree health insurance benefit. An employee who was hired before July 1, 2016 and who officially retires from the university and receives a monthly benefit from the Educational Retirement Board immediately upon termination of employment (those eligible under the Alternative Retirement Plan must meet eligibility rules and immediately begin receiving a benefit) may elect to continue medical insurance after retirement, providing the employee had been covered under the plan for the prior 10 consecutive years and worked in a regular employment status. Time while enrolled as an employee or as a spouse of an active employee will be counted toward the 10 years, provided there is no gap in coverage during the 10 year period. Coverage as the spouse/qualified domestic partner of a retiree will not be credited toward the 10 years. The university continues to pay a percentage of the premium. When a retiree or dependent becomes age 65 and/or eligible for Medicare, all medical coverage will be moved to the Medigap Plan G, which includes a Medicare Part D prescription plan. If the retiree or dependent enrolls in a Medicare Part D prescription plan outside the university retiree plan, they will no longer be eligible to access prescription or medical coverage through the retiree medical plan. Details regarding coverage, eligibility and restrictions are available through the Office of Human Resources. The university reserves the right to unilaterally increase, decrease or discontinue coverages, plan provisions, and premiums.

ELIGIBLE FAMILY MEMBERS

Covered family member, covered spouse, covered child – An eligible spouse, qualified domestic partner or eligible child (as defined below) who has applied for and been granted coverage under the subscriber’s policy based on his/her family relationship to the subscriber.

Eligible family members – Family members of the subscriber, limited to the following persons:

- the subscriber’s legal **spouse**
- the subscriber’s eligible **child** through the end of the month in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from coverage and rates adjusted accordingly – unless the child is an eligible family member under this Plan due to a disability as described below.)
- the subscriber’s **unmarried** child age 26 or older who was enrolled as the subscriber’s covered child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled**, chiefly dependent upon the subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability (Such condition must be certified by a physician and BCBSNM. Also, a

child may continue to be eligible for coverage beyond age 26 only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition before the end of the month during which the child's coverage would otherwise end.)

- the subscriber's **domestic partner**

Eligible child - The following family members of the subscriber through the end of the month during which the child turns age 26:

- natural or legally adopted child of the subscriber
- child placed in the subscriber's home for purposes of adoption (including a child for whom the subscriber is a party in a suit in which the adoption of the child by the subscriber is being sought)
- stepchild of the subscriber (or otherwise eligible child of a domestic partner, if domestic partners are covered under your benefit plan)
- child for whom the subscriber must provide coverage because of a court order or administrative order pursuant to state law
- child of a domestic partner (1) if either of the domestic partners is the biological parent of the child or (2) if either or both parents are adoptive parents of the child or (3) if the child has been placed in the domestic partner's household as part of an adoptive placement

A child meeting the criteria above is an "eligible child" whether or not the subscriber is the custodial or noncustodial parent, and whether or not the eligible child is claimed on income tax, employed, married, attending school or residing in the subscriber's home, **except** that:

- A child age 19 or older who has other group coverage available to him/her whether through the child's own employer or through the child's spouse's employer - is not eligible under this health plan. The child need not be enrolled in such available group coverage in order to be excluded as an eligible family member.
- once the subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, or stepchild of the subscriber in order to retain eligibility as a family member under this health plan.

A **domestic partner** is a person of the same or opposite sex who meets all of the requirements by NMSU.

In addition, you and your domestic partner will meet the terms of this definition as long as neither of you nor your domestic partner:

- has signed a domestic partner affidavit or declaration with any other person within 12 months prior to designating each other as domestic partners hereunder;
- is currently legally married to another person; or
- has any other domestic partner, spouse, or spouse equivalent of the same or opposite sex.

You and your domestic partner must have registered as domestic partners if you reside in a state that provides for such registration. In any case, if your employer allows coverage for domestic partners and their children, BCBSNM will require a notarized *Affidavit of Domestic Partnership* and any other supporting documentation required by the employer.

Employees wanting to change benefit elections involving a domestic partner must adhere to the same rules regarding qualifying events.

BCBSNM may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an eligible family member under this coverage. Unless listed as an eligible family member, no other family member, relative or person is eligible for coverage as a family member. Common-law spouses are **not** considered legal spouses; in order to be considered eligible for coverage, a common-law spouse must meet the definition of "domestic partner."

Covered family member, covered spouse, covered child - An eligible spouse or eligible child (as defined above) who has applied for and been granted coverage under the subscriber's policy based on his/her family relationship to the subscriber.

Eligible family members cannot participate in the NMSU program unless the eligible retiree participates (although a surviving spouse and any other survivor's eligible children who were covered at the time of the retiree's death may continue participating.) Note: If all eligible members of a retiree's family do not qualify for enrollment in the NMSU PPO Plan due to being age 65 or older or due to entitlement to Medicare as primary coverage, the unqualified members will be enrolled in the NMSU Medigap Plan G. (If the member has only one Part of Medicare, he/she is not eligible to enroll in any NMSU health plan but may choose to continue coverage under one of the continuation options listed under "How Coverage May Continue".)

Family Members Who are Not Eligible – A retiree's spouse, domestic partner, or child is not an eligible family member while:

- on active duty in the armed forces of any country (unless eligible for continued coverage for a limited period of time under federal law); or
- covered under this Plan or another plan of benefits provided through NMSU for health care expenses as an employee or retiree or an eligible family member of another employee or retiree.

Information for Noncustodial Parents

When a child is covered by the Plan through the child's noncustodial parent, then the Plan will:

- provide such information to the custodial parent as may be necessary for the child to obtain benefits through the Plan;
- permit the custodial parent or the provider (with the custodial parent's approval) to submit claims for covered services with the approval of the noncustodial parent; and
- make payments on claims submitted in accordance with the above provision directly to the custodial parent, the provider, or the state Medicaid agency as applicable.

MEDICARE-ELIGIBLE MEMBERS

Shortly before you turn age 65 or qualify for Medicare benefits for other reasons, you are responsible for contacting the local Social Security office to establish Medicare eligibility. You should then contact your benefits administrator to discuss coverage options.

If an active employee qualifies under the provisions of federal law for the working aged (TEFRA), then the working employee age 65 or older and/or his/her eligible spouse age 65 or older who is covered by Medicare may continue this Plan coverage as primary over Medicare until the eligible employee retires.

A member under age 65 receiving Medicare benefits due to disability or end-stage renal disease (ESRD) also has primary benefits under this Plan coverage, but for only a limited period of time. (For ESRD patients, this Plan coverage is primary only during the CMS-defined ESRD coordination time period – usually 30 months after the start of dialysis. Medicare becomes primary when the Medicare ESRD coordination time period expires.)

In any case, if you are a Medicare beneficiary and you actively *select* Medicare as your primary coverage, this Plan is **not** available to you, and your employer may not offer you any other employer-sponsored health care plan.

Refer to a Medicare Handbook or contact the Social Security Administration for more information and eligibility guidelines that apply to you.

APPLYING FOR COVERAGE

Eligible employees must contact NMSU Benefit Services for application into the BCBSNM PPO Plan prior to the retirement date.

WHEN COVERAGE BEGINS

Coverage under this Plan begins on the date of the employee's retirement. Your NMSU health plan ID card indicates the subscriber's name under the NMSU PPO Plan. When the retiree is under age 65 and not Medicare eligible, the subscriber name is the retiree name. In the event the retiree becomes Medicare eligible and moves to the NMSU Medigap Plan G, the continuing members of the family on the PPO plan become the subscriber.

Change in Health Care Plan

If you or your eligible family member must change to the Medigap Plan G health care plan due to Medicare eligibility, you must provide NMSU Benefit Services with a copy of the Medicare Part A and Part B card prior to the effective date of Medicare. It is important that you contact Benefit Services in order to confirm your termination under one plan with the effective date under the new plan and to verify your premiums have been adjusted. See “Premium Payments” for details.

Upon attainment of age 65, NMSU will automatically enroll you and/or your eligible family members in the Medigap Plan G upon receiving a copy of your/your family member’s Medicare Part A and B card.

Note: If a retiree or an eligible family member of a retiree/surviving spouse must switch to the Medigap Plan G health care plan for any reason other than reaching age 65, the change will become effective the next first of the month following the date of the event that necessitated the change.

PREMIUM PAYMENTS

If a coverage change results in a higher premium, you will be responsible for paying any additional amounts due beginning the effective date of the change.

NMSU is solely responsible for premium payments and premium collections.

Premium Increases/Decreases – When a retiree experiences a change in status (including but not limited to: marriage, divorce, childbirth, adoption, Medicaid enrollment, family member no longer meeting insurance eligibility rules), the retiree has 31 days from the date of the status change to contact Benefit Services to make coverage changes. All status changes resulting in insurance coverage and/or premium change will be effective the first day of the month following the date of the change in status, except in the case of a newborn or the placement of child(ren) through adoption. For a newborn or placement of child(ren) through adoption, coverage becomes effective the date of birth or date of placement. The addition of a child through birth or placement will result in a full premium being charged if effective the 1st through the 15th of the month.

See “Coverage Termination” for termination dates that apply to specific circumstances. See “Applying for coverage: Change in Health Care Plan” for dates upon which you can switch enrollment to another plan.

Premiums for Retirees – Retiree coverage begins on the date of retirement from NMSU. NMSU continues to pay a portion of the Plan’s premium (except as listed under “Adding a New Spouse/Domestic Partner”).

Premiums for Surviving Spouse/Qualified Domestic Partner and His/Her Eligible Children – If a retiree dies, the surviving eligible spouse/qualified domestic partner and his/her surviving eligible children who were covered at the time of the retiree’s death may continue coverage (see Coverage Termination for more information). Coverage for the spouse/domestic partner ends if the person remarries or enters into a new domestic partnership. Surviving eligible family members are responsible for paying 100 percent of their premiums to NMSU in order to retain coverage.

Premiums for Continuing Members – See “How to Continue Coverage” for details.

Notification – If the Group Master Contract is terminated or premiums are not submitted, coverage will terminate for all affected members at the end of the last-paid billing period. BCBSNM will not notify the affected members of such termination. (If NMSU fails to submit premium payments to BCBSNM, it is NMSU’s responsibility to advise members of BCBSNM Plan termination.)

The required premiums are determined and established by BCBSNM. The percentage of the total premium that you pay is established by NMSU. BCBSNM may change premium amounts according to any of the following:

- changes in federal and state law, or
- changes to coverage classification (for example, to a new age category or geographic location, or from a single eligible family member coverage to a two eligible family member coverage type), or
- after giving the employer and/or subscriber 60 days written notice.

Premium Refunds – BCBSNM may not refund membership premiums paid in advance on behalf of a terminated member if:

- the enrollment/change form is not received within 31 days of the change in eligibility status; or
- any claims amounts that have been paid on behalf of the terminated member during the period for which premiums have been paid.

ADDING A FAMILY MEMBER TO COVERAGE

A retiree may apply only for coverage of a new spouse or domestic partner or a newly born child or child adopted after retirement. Surviving eligible family member contract holders may not add new family members to coverage.

Adding a New Spouse or a Qualified Domestic Partner

New spouses or qualified domestic partners acquired by a retiree after retirement may be added to either the NMSU PPO or the NMSU Medigap Plan G, as applicable, under certain circumstances. The new spouse or domestic partner will not be added until one year following the date of marriage or creation of partnership.

In order to add a new spouse or qualified domestic partner, a completed and signed enrollment/change form must be submitted to Benefit Services, along with a copy of the marriage certificate or all required domestic partnership documentation, as applicable. You have **31 days** following your first anniversary date of marriage (or partnership) in which to submit the completed paperwork. For domestic partner relationships, the date of the notarized signatures on the affidavit will serve as the effective date of the relationship.

There will be no NMSU contributions to the additional premium cost (NMSU will continue to pay applicable premium for the retiree's coverage), and the retiree will be responsible for paying 100 percent of the premium for the new spouse's or domestic partner's coverage.

The new spouse or qualified domestic partner will be eligible for surviving spouse/domestic partner benefits if he/she is a member of the NMSU health plan when the retiree passes away. If the retiree passes away before the new spouse/domestic partner's coverage becomes effective, the new spouse/domestic partner will not be eligible for health insurance coverage through NMSU as a surviving spouse/domestic partner.

New Spouses/Qualified Domestic Partners of Continuation Subscribers – Federal continuation subscribers may add new spouses or domestic partners to coverage (if such addition would have been allowed under the coverage immediately preceding the continuation policy) by submitting a completed and signed enrollment/change form to the federal COBRA administrator (HCSC). (Surviving spouses/domestic partners and children who are covered under the survivor's continuation policy may not add new spouses, domestic partners, or children to federal continuation coverage.)

Adding an Eligible Child

Retirees/retiree spouses may add eligible children to coverage in the following cases. These provisions do not apply to surviving spouses/domestic partners, whether covered under the group plan or under the federal continuation coverage. If a child is not added to coverage within the time frames listed below, the child may not obtain NMSU coverage at a later date.

Newborn Children

Even if you have Family coverage, you must submit an enrollment/change form to add the newborn as an eligible family member within 31 days of birth. This will ensure that the newborn is added to our membership records as an eligible family member in a timely manner and that claims payments will not be delayed unnecessarily. If Family coverage is not in effect, you must change to Family or Retiree/Child(ren) coverage within 31 days of the birth in order for newborn care to be covered. The baby will then be covered from birth.

Note: If the parent of the newborn is an eligible child of the subscriber (i.e., the newborn is the subscriber's grandchild), benefits are **not** available for the newborn.

Adopted Children

A child under age 18 placed in the retiree's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as 31 days following legal adoption without being considered late. Depending on when you submit the application to Benefit Services, the effective date of coverage will be the date of placement in the home or date of legal adoption if you submit the application within 31 days of the applicable event. (Although a child over the age of 18 is not eligible for adoption, an adopted child is covered as any other child, subject to the same eligible child age limitations and restrictions.) If the 31-day deadline is not met, there will not be an option to add the child at a later date.

Disabled Children

A retiree's child who is covered under Medicaid due to disability and who loses his/her Medicaid eligibility may be added to coverage. Proof of the loss of coverage will be required and the retiree has 31 days from the date the child loses Medicaid to add the disabled eligible child. If the 31-day deadline is not met, there will not be an option to add the child at a later date.

Legal Guardianship

Application for coverage must be made for a child for whom the retiree or the retiree's spouse becomes the legal guardian **within 31 days** of the court or administrative order granting guardianship. If not specified in the court order, the eligible child's effective date of coverage will be the date the order has been filed as public record with the State, or the effective date of Family or Retiree/Child(ren) coverage, whichever is later. If the 31-day deadline is not met, there will not be an option to add the child at a later date.

Stepchild

Application for coverage must be made for a stepchild **within 31 days** of the marriage to the stepchild's biological parent.

Court Ordered Coverage for Children

When an employee or employer is required by a court or administrative order to provide coverage for an eligible child, the eligible child may be enrolled in the subscriber's Family coverage, or Employee/Children coverage, if available and will **not** be considered a late applicant. (If the subscriber has Individual coverage, he/she may be required to pay additional premium in order for the eligible child to be added.) If not specified in the court or administrative order, the eligible child's effective date of coverage will be the date the order has been filed as public record with the State or the effective date of Family coverage, or Retiree/Child(ren) coverage, if available, whichever is later. If the 31-day deadline is not met, there will not be an option to add the child at a later date. BCBSNM must receive a copy of the court or administrative order.

LATE APPLICANT

Unless eligible for a special enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage. For example, a newborn child added to coverage more than 31 days after birth when, for example, Family coverage (or Employee/Children coverage, if available) is not already in effect, a child added more than 31 days after legal adoption, a domestic partner and/or his/her eligible children added to coverage more than 31 days after becoming eligible, or a new spouse or stepchild added more than 31 days after marriage is considered a late applicant. Note: Even if you have Family coverage, you should submit an enrollment/change form to add a newborn to coverage within 31 days of birth. This will ensure that the newborn is added to your membership records as an eligible family member in a timely manner and that claims payments will not be delayed unnecessarily.
- anyone enrolling on the group's initial BCBSNM enrollment date who was not covered under the group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as a provider under USERRA of 1994)

Late applications are not accepted from retirees, their eligible family members, or their surviving eligible family members.

SPECIAL ENROLLMENT

You have a limited amount of time during which you may request a special enrollment. If you do not request special enrollment within the time frame described below, you will be considered a late applicant. Note: There is no special enrollments for persons applying for any continuation, conversion coverage. You must enroll in such coverage timely.

Waiving Coverage

A retiree who declines coverage at retirement and later loses other coverage will not be entitled to special enrollment (and neither will the retiree's eligible family members).

Coverage Effective Date

If a member is granted a special enrollment due to involuntary loss of Medicaid, birth, or adoption, due to premium assistance eligibility, or due to marriage, and all required documentation is received timely by the employer, coverage will begin no later than the first day of the month after the employer received the request for special enrollment. However, for a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption.

If a completed and signed enrollment/change form is **not** received within the time periods set forth in this section, the employee and /or his /her eligible family members will be considered late applicants and no special enrollment right will be available.

Qualifying Event: Change in Family Status

A retiree who acquires a new eligible family member due to marriage, a domestic partner, birth, adoption, or placement for adoption may apply for a special enrollment in this Plan for family members who are eligible for coverage under this Plan. Application for special enrollment of the retiree's eligible family members will not be considered late if submitted within 31 days of the marriage, birth, adoption, or placement of the eligible child in the subscriber's home, or marriage within 31 days on the on year anniversary of the marriage. If submitted more than 31 days following the change in family status, special enrollment is not available.

- **Newborn or Adopted Child:** For a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption (or, if earlier, on the date of placement in the subscriber's home).
- **Marriage:** The effective date of coverage for all persons granted a special enrollment due to marriage will be the same as the new spouse's effective date of coverage, which is one year following the date of marriage, as described under "Adding an Eligible Family Member to Coverage."

COBRA Continuation Policy Members

If you are covered under a COBRA continuation policy, you must contact the COBRA administrator. The name, address, and phone number of the administrator will be provided to you should you elect COBRA coverage.

COVERAGE TERMINATION

Unless stated otherwise, if you do not elect or do not qualify for continuation coverage (see "How to Continue Coverage"), coverage ends at the end of the month following termination event or request listed below:

- The date the member loses eligibility for coverage according to NMSU's rules and regulations. If NMSU fails to notify BCBSNM or the subscriber fails to notify NMSU to remove an ineligible person from coverage by submitting a completed enrollment/change form to NMSU, BCBSNM may recover any benefit payments from the subscriber/provider who received such payments that were made on the ineligible person's behalf. It is the subscriber's responsibility to notify Benefit Services when a member loses eligibility status. If the member rescinds his/her retirement through NMERB or NMARP, he/she will be dropped from the NMSU retiree plan.
- When a discontinuance form is signed and received by Benefit Services.

- When NMSU does not receive the premium payment for coverage from the subscriber on time. (Coverage will be suspended if premium is not paid when it is due. If premium is not received within 31 days after its due date, the affected member(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 31-day grace period will be billed to the subscriber.)
- When BCBSNM does not receive the applicable payment from NMSU, according to the agreement set forth in the Group Master contract, on time. (Coverage will be suspended if amounts are not paid when due. If not received within 60 days after its due date, NMSU or the affected members(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 60-day grace period will be billed both to the subscriber and to NMSU.)
- When the member materially fails to abide by the rules, misrepresents information affecting coverage. If a member knowingly gave false material information in connection with the eligibility or enrollment of the subscriber or any of his/her covered family members, BCBSNM and NMSU may terminate the coverage of the subscriber and his/her covered family members retroactively to the date of initial enrollment. The subscriber is liable for any benefit payments made as a result of such improper actions.
- When the subscriber dies. (Surviving eligible spouses, domestic partners, and eligible children may remain covered under the NMSU health care plan under certain circumstances. Contact Benefit Services for details. If the surviving family members are not eligible for continued coverage, coverage ends on the last day of the month following the retiree's death.)
- At the end of the month prior to a retiree or his/her eligible family member becoming eligible for Medicare. (Such persons must enroll in the NMSU Medigap Plan G. If not enrolled in Parts A and B of Medicare, the retiree and his/her eligible family members may be eligible for continued coverage under "How Coverage May Continue.")
- At the end of the month prior to a retiree or retiree's spouse or other eligible family members reaching age 65 (regardless of Medicare enrollment). (Such persons must enroll in the NMSU Medigap Plan G if eligible for Parts A and B of Medicare. Retirees and their eligible family members, including surviving family members, that are not enrolled in Parts A and B of Medicare may be eligible for continued coverage only as specified under "How Coverage May Continue.")
- On the day when the member acts in a disruptive manner that prevents the orderly business operations of any Participating Provider or dishonestly attempts to gain a financial or material advantage.
- On the day when group coverage is discontinued for the entire group or for the retiree's/surviving eligible family member's enrollment classification.
- When NMSU gives BCBSNM a minimum 30 days advance written notice of contract termination, or BCBSNM gives NMSU a minimum 90 days advance written notice of contract termination.

If BCBSNM ceases operations, BCBSNM will be obligated for services for the rest of the period for which premiums were already paid.

Notification - If the Group Master Contract is terminated or premiums are not submitted, coverage will terminate for all affected members as of the end of the last-paid billing period. BCBSNM will not notify the affected members of such terminating. (If NMSU fails to submit premium payments to BCBSNM, it is NMSU's responsibility to advise members of BCBSNM Plan termination.)

Additional Family Member Termination Reasons

In addition, coverage will end for any family member on the earliest of the above dates or the earliest of the following dates:

- at the end of the **last-paid billing period** for Family coverage;
- at the end of the month when a child **no longer qualifies as an eligible child** under the Plan (e.g., a child is removed from placement in the home or reaches the eligible child age limit);
- at the end of the month following the date of a final **divorce** decree or **legal separation** for a spouse;
- at the end of the month when the subscriber gives notice in writing to end coverage for a covered family member(s), according to the rules of your Plan as established by your employer.
- at the end of the month following the dissolution of a domestic partnership.

- at the end of the month when eligible family members enters the armed forces for more than 30 days (or as provided by law).

To remove an ineligible family member from coverage, you must submit a completed and signed enrollment/change form to Benefit Services. The affected member will be removed from coverage on the last day of the month following his/her loss of eligibility.

If an eligible family member is being removed from coverage because of losing his/her eligibility under the Plan, NMSU Benefit Services will automatically cancel this dependent and provide the member with a notice of change in premium cost. If such notice is not received by the member prior to the end of the month in which the dependent reaches the qualifying age, the member should contact NMSU Benefit Services. If an eligible family member loses eligibility due to divorce or dissolution of domestic partnership, the member must complete an enrollment/change form with NMSU Benefit Services. If claims payments are made for an ineligible member (for example, due to late notification), BCBSNM and the providers of care may recover benefits erroneously paid on behalf of the ineligible person.

Cancellation Appeals

BCBSNM will not terminate your coverage based solely on your health status or health care needs. If you believe that your coverage is being canceled due to health status or health care requirements, you may appeal cancellation to the NM Public Regulation Commission:

NM Public Regulation Commission, Insurance Division
P.O. Box 1269
Santa Fe, NM 87504-1269

You may also call the Insurance Division toll-free at (800) 947-4722.

Voluntary Termination of Coverage

To remove a family member from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, you must submit a completed enrollment/change form to NMSU (or to the state or federal continuation plan administrator, if applicable.) Voluntarily terminated members may not re-enroll under the Plan. Also, these members are **not** eligible for any extension of benefits or federal or state continuation or conversion coverage.

If you are a retiree, you may voluntarily remove eligible family members from coverage at any time and your premiums will be adjusted as stated under “Premium Payments” earlier in this section. Coverage will end at midnight on the last day of the month the signed and completed enrollment/change form is received by Benefit Services.

Retirees and their eligible family members (including surviving spouses and/or other eligible family members) and continuation subscribers/eligible family members who voluntarily terminate before losing eligibility may not enroll at any time.

RE-ENROLLMENT

A retiree who returns to work full-time and later re-retires may only continue coverage for eligible family members who were covered under the health plan at the time of re-retirement except as defined in the “Adding an Eligible Family Member to Coverage” section. If coverage is voluntarily discontinued after retirement by a retiree or surviving eligible family member contract holder for self or for any covered family member, the retiree and/or the eligible family member may not re-enroll at any time.

Any individual whose previous BCBSNM contract was terminated for good cause is not eligible to re-enroll in this Plan, unless approved in writing by BCBSNM. (Members currently enrolled in continuation coverage may not re-enroll once coverage is terminated, unless eligibility under this Plan is re-established.)

If coverage is voluntarily discontinued by a COBRA member, the terminated member may not re-enroll at any time.

Termination of Continuation Coverage or Extension of Benefits

See “How to Continue Coverage” for more information.

Leave of Absence or Military Service

Coverage will end for a subscriber and his/her eligible family members at the end of the month during which the leave began. During a leave of absence covered by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Contact your benefits administrator for information.

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The subscriber must notify Benefit Services of any changes that may affect his/her or a family member's eligibility (such as a change in Medicare eligibility status, marital status, or age), including a change to a covered family member's name or address. (Members covered under COBRA continuation obtain forms from an NMSU Designated Service Unit (DSU) representative at BCBSNM and do not submit enrollment/change forms to NMSU; see *How to Continue Coverage* for applicable address.)

PREMIUM REFUNDS

BCBSNM may not refund membership premiums paid in advance on behalf of a terminated member if:

- the enrollment/change form is not received **within 31 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated member during the period for which premiums have been paid.

HOW TO CONTINUE COVERAGE

If you lose coverage under this Plan, you may be able to continue coverage for a limited period of time. **Note:** There is no special enrollment under these provisions. You must enroll timely to qualify for continued coverage.

Federal Continuation (COBRA)

NMSU is subject to the provisions for continuation of Plan coverage under the 1985 federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA). Therefore, surviving eligible children, and the covered family members of retirees and surviving eligible children who lose eligibility under this group health care plan may be able to continue as members, without a health statement, for a limited period of time. You must pay premiums from the date of loss of group coverage.

This information is a summary of the law and therefore is general in nature. The law itself and the actual provisions of the medical plan must be consulted with regard to the application of these provisions in any particular circumstances. If you have any questions about the law, please contact NMSU Benefit Services.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage is provided subject to your eligibility for coverage under the medical plan. NMSU reserves the right to terminate your continuation coverage retroactively if you are determined ineligible.

Contact Benefit Services for details about enrolling in continuation coverage.

Continuation Benefits (COBRA) - If you choose federal continuation coverage, NMSU is required to give you coverage which, as of the time coverage is being provided under the Plan to similarly situated retirees or family members. However, if the coverage for regular members changes, your continuation coverage will reflect the same change. For example, if the Plan's deductible changes for regular members, your deductible will change by the same amount.

Qualifying Events and Qualified Beneficiaries - anyone who voluntarily terminated coverage while still eligible or whose coverage was terminated for good cause (as defined in the Definitions section) is not eligible for continued coverage under this provision.

Under provisions of the law, eligible family members(s) may continue coverage in the medical plan following certain qualifying events.

Eligible family members may choose to continue coverage until the last day of the month following 36 months after these qualifying events:

- an enrolled retiree's death (However, surviving eligible family member benefits may be available to you as well. If you do obtain survivor spouse coverage, you are not a qualified beneficiary under this provision and would not be eligible for continuation coverage once you remarry and lose group coverage. Loss of coverage due to re-marriage of a surviving spouse is not a qualifying event. A surviving eligible child would be eligible for continuation plan coverage if he/she subsequently loses group plan coverage due to a qualifying event.)
- divorce or legal separation from an enrolled retiree (dissolution of domestic partnership is not a qualifying event, but domestic partners are eligible for continuation coverage under any other applicable event listed here)
- a child ceases to be an eligible child under the medical plan
- Medicare entitlement by retiree that causes eligible family members to lose continuation coverage (This provision is not applicable to NMSU retiree or their eligible family members. If a retiree becomes entitled to Medicare, the retiree transfers to the NMSU Medigap Plan G and eligible family members remain under this NMSU PPO plan until either losing eligibility or until retiree loses NMSU coverage. If the retiree loses coverage, continuation coverage is available as stated in this section.)

The definition of qualified beneficiary for COBRA purposes also includes a child born to , or placed for adoption with, a covered retiree during the period of the retiree's continuation coverage. Thus once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other COBRA qualified beneficiaries.

Who is Not Eligible - Unless approved in writing by BCBSNM, the following persons may **not** enroll in this continued coverage option:

- one who **voluntarily** terminated coverage while still eligible (*Involuntary termination* includes loss of coverage under the following situations only: legal separation, divorce, loss of eligible child eligibility status, death of the subscriber, termination of employment, reduction in hours, or termination of employer contributions. Any other reason is considered voluntary.)
- a covered family member who was removed from coverage by the subscriber while the family member was still eligible
- any member whose BCBSNM health care coverage was terminated for good cause
- a surviving spouse who loses coverage due to remarriage

You are also not eligible to enroll for continuation coverage if:

- the employer stops offering this coverage to its retirees or their surviving family members, or
- you do not elect continuation coverage in a timely fashion.

Notification Responsibilities - While covered under COBRA the affected member has the responsibility to inform Health Care Service Corporation (HCSC) of a divorce, legal separation, or child losing eligible child status under the medical plan within 60 days of the date of the event or the date on which coverage would end under the program because of the event, whichever is later. In all other cases, (e.g., subscriber's death or Medicare entitlement, divorce or legal separation, or other eligible family member loss of eligibility, such as a surviving spouse's remarriage) the subscriber, his/her personal Representative, or the affected eligible family member is responsible for ensuring that Benefits Services is notified in a timely manner.

When BCBSNM is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or the date notice of your election rights is sent to you, whichever is later, to elect continuation coverage on the forms provided by BCBSNM.

Maximum Continuation Periods - This law requires that eligible family members of retiree be afforded the opportunity to maintain continuation coverage for 36 months.

Cost of Continuation Coverage – The cost of the coverage will not be more than 102 percent of the applicable group rate during the period of basic COBRA coverage.

Termination of Continuation Coverage – The law provides that your continuation coverage may be terminated for any of the following reasons:

- NMSU no longer provides group health coverage to any of its retiree or surviving eligible family members. (If this Plan is replaced by another health care plan, continuation coverage will also be placed by the new plan.) Exception: If NMSU declares bankruptcy and you are covered under this Plan as a retiree, you and your eligible family members may be eligible for continued coverage.
- The premium for your continuation coverage is not paid on time.
- You become covered by another group plan that begins coverage after your COBRA election.
- The continuation period expires.
- You enroll in and become covered by Medicare. (Eligible family members who were covered under the continuation plan when you enrolled in Medicare will then be eligible to remain on COBRA continuation for up to 36 months of coverage, starting from the initial qualifying event.)

Once your continuation coverage terminates for any reason, it cannot be reinstated.

Customer Service – The COBRA administrator is Health Care Service Corporation. This corporation collects premium and administers eligibility only. Questions about your billing or eligibility under COBRA should be directed to:

Health Care Service Corporation
P.O. Box 2387
Danville, IL 61834-2387
Toll-Free Telephone Number: (888) 541-7107

Reminder: Do not send claims related questions to the above address.

Continuation Benefits

Your group may be subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA). If so, employees and their covered family members excluding domestic partners who lose eligibility under this group health care plan may be able to continue as members, without a health statement, for a limited period of time by purchasing the continuation coverage described below. You must pay premiums from the date of loss of group coverage.

You are not eligible to enroll for continuation coverage if:

- the employer stops offering this coverage to its employees, *or*
- you do not elect continuation coverage in a timely fashion.

Premium Payments

Subscribers under federal COBRA continuation coverage must pay premiums to the COBRA administrator. Contact your benefits administrator for an application for coverage and details.

Premiums for coverage may change on your group's renewal date or on any date that the Plan is amended. Written notice of any such change will be given to the Group or Subscriber at least 60 days before the effective date of the premium change.

USERRA Continuation Coverage

Employees and their covered family members who lose group coverage because the employee is absent from work due to military service may be able to continue coverage for **up to 24 months** after the absence begins. Contact your benefits administrator for details about the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Extension of Benefits

If you are totally disabled on the date your group terminates coverage, your health care coverage may be continued (for only the disabling condition) for **up to 12 consecutive months** after the group terminates coverage with BCBSNM.

An extension of benefits is available if you:

- were totally disabled on the date of the group's termination; *and*
- incur an expense directly resulting from that particular disability that would have been a covered service before termination.

If coverage is continued under this provision, benefits for the disabling condition are paid subject to all applicable limitations, exclusions, and maximums that applied at the time the group's coverage terminated. To claim an extension of benefits, you must notify BCBSNM **within 31 days** of the group's coverage termination date and provide evidence of your total disability.

CONVERSION TO INDIVIDUAL COVERAGE

Members of the group insured have the right to continue coverage for a period of six months and thereafter through a conversion policy upon termination of membership or employment with the group insured. Covered family members of an employee or member of the group insured have the right to continue coverage through a converted or separate policy upon the death of the member or employee of the group insured or upon divorce, annulment or dissolution of marriage or legal separation of the spouse from the member or employee of the group insured.

Where continuation of coverage or conversion is made in the name of the spouse of the named insured or the spouse of the group insured or member of the group insured, such coverage may, at the option of the spouse, include coverage for dependent children for whom the spouse has responsibility for care and support.

The right to a continuation of coverage or conversion shall not exist with respect to any member or employee of the group insured or any covered family member in the event the coverage terminates for nonpayment of premium, non-renewal of the policy or the expiration of the term for which the policy is issued. With respect to any member or employee of the group insured or any covered family member who is eligible for medicare or any other similar federal or state health insurance program, the right to a continuation of coverage or conversion shall be limited to coverage under a medicare supplement insurance policy as defined by the rules and regulations adopted by the superintendent.

Coverage continued through the issuance of a converted or separate policy shall be provided at a reasonable, nondiscriminatory rate to the insured and shall consist of a form of coverage then being offered by BCBSNM as a conversion policy in the jurisdiction where the person exercising the conversion right resides that most nearly approximates the coverage of the policy from which conversion is exercised. Continued and converted coverages shall contain renewal provisions that are not less favorable to the insured than those contained in the policy from which the conversion is made, except that the person who exercises the right of conversion is entitled only to have included a right to coverage under a medicare supplement insurance policy, as defined by the rules and regulations adopted by the superintendent, after the attainment of the age of eligibility for medicare or any other similar federal or state health insurance program.

At the time of inception of coverage, BCBSNM shall furnish to each covered family member who is eighteen years of age or over and to each employee or member of the group insured a statement setting forth in summary form the continuation of coverage and conversion provisions of the policy.

BCBSNM shall notify in writing each employee or member, upon that employee's or member's termination of employment or membership with the group insured, or the continuation and conversion provisions of the policy. The employer may give the written notice specified herein. The employer should notify BCBSNM of the employees's or members's change of status and last known address. Under no circumstances shall the employer have any civil liability under the conversion provisions of New Mexico law.

The eligible employee or member of the group insured or covered family member exercising the continuation or conversion right shall notify the employer or BCBSNM and make payment of the applicable premium within thirty days following the date of the notification given BCBSNM. There shall be no lapse of coverage during the period in which conversion is available;

Coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations other than those remaining unexpired under the policy or contract from which continuation or conversion is exercised;

Benefits otherwise payable under a converted or separate policy may be reduced so they are not, during the first policy year of the converted or separate policy, in excess of those that would have been payable under the policy from which conversion is exercised. Benefits, if any otherwise payable under a converted or separate policy are not payable for a loss claimed under the policy from which conversion is exercised; and

Any probationary or waiting period set forth in the converted or separate policy is deemed to commence on the effective date of the applicant's coverage under the original policy.

SECTION 3: HOW YOUR PLAN WORKS

BENEFIT CHOICES

This health care plan is a Preferred **Plus**-Provider Option (PPO) health care plan that gives you the opportunity to save money, while providing you choice and flexibility when you need medical/surgical care and preventive services. When you need health care, you have the choice of obtaining benefits from either a Preferred Provider or a Nonpreferred Provider. It's important to understand the differences between them. When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a BCBSNM Preferred Provider. (A physician's or other provider's contract may be separate from the facility's contract.) Your choice can make a difference in the amount you pay and the benefits available to you.

Your Choices

	Preferred Provider	Nonpreferred Provider
Cost-Sharing Differences	<p>PPP office visit charges are not subject to deductible. You pay only a fixed-dollar copayment only.</p> <p>Other services of a PPP are subject to an annual deductible and a percentage of covered charge (coinsurance) after the deductible is met.</p> <p>You have an annual out-of-pocket limit, after which services normally subject to deductible and coinsurance, are paid at 100% of the covered charge. The limit includes only coinsurance for Preferred Provider services.</p>	<p>You pay a higher percentage of covered charges and have a higher deductible to meet. You have a higher annual out-of-pocket limit that includes only coinsurance for Non-referred Provider services.</p> <p>Nonpreferred Provider are not eligible for the fixed-dollar PPP office visit copayment; such services are subject to an annual deductible and coinsurance.</p> <p>Benefits for some services received from Nonpreferred Providers (e.g., durable medical equipment, prosthetics) are limited each year to the amount specified on the Summary of Benefits.</p>
Covered Charge vs. Billed Amount	<p>If the covered charge is less than the billed amount, the Preferred Provider will write off the difference. You pay only copayments, coinsurance, noncovered expenses, and penalty amounts, if any.</p>	<p>The Nonpreferred Provider may bill you for amounts over the covered charge. This amount is not applied to your deductible and is not applied to your out-of-pocket limit. The payment of these excess charges is solely your responsibility.</p>
Filing Claims	<p>The Preferred Provider is responsible for filing claims directly to the local BCBS Plan.</p>	<p>You may have to pay the Nonpreferred Provider in full and submit your own claims; the decision is up to the provider.</p>
Requesting Preauthorizations	<p>Preferred Providers that contract directly with BCBSNM are responsible for requesting all necessary preauthorizations on your behalf. (Providers that contract with another BCBS Plan (i.e., BCBS of Texas) may call for preauthorization on your behalf, but you will be responsible for making sure that preauthorization is obtained when required.)</p>	<p>Nonpreferred Providers may call for preauthorizations on your behalf, but you are responsible for making sure that all preauthorizations are obtained when required.</p>
Available Benefits	<p>All services covered under this Plan are eligible for coverage at the Preferred Provider benefit level. (Specialist cost-sharing provisions apply to certain transplants.)</p>	<p>Some benefits are not available unless services are received from a Preferred Provider. See the <i>Summary of Benefits</i> for a list of services not covered at the Nonpreferred Provider benefit level, if applicable.</p>

Although you can go to the hospital or physician of your choice, benefits under the PPO program will be greater when you use the services of a Preferred Provider.

PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

Preferred Providers are health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as “Preferred” or “PPO” Providers. These providers have agreed to provide health care for PPO plan members and accept the Plan’s payment for a covered service plus the member’s share of the covered charge (i.e., deductible, coinsurance, copayment and/or penalty amounts, if any) as payment in full.

Nonpreferred Providers are providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the “Preferred” or “PPO” Provider network. (These providers may have “participating” provider agreements, but are **not** considered preferred. See *Section 8: Claim Payments and Appeals* for more information.)

When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a Preferred Provider. (A physician’s or other provider’s contract may be separate from the facility’s contract.)

Pursuant to 13.10.22.8C.(1) NMAC, a member shall not be held liable for payment of services if a BCBSNM Participating Provider mistakenly makes a referral to a non-Participating Provider, unless BCBSNM has notified the member in writing concerning the use of non-Participating Providers and informed the member that BCBSNM will not be responsible for future payment to the non-Participating Provider.

Covered Charges
*For covered charges related to claims from providers that contract directly with BCBSNM, see “Covered Charges” in <i>Section 8: Claims Payments and Appeals</i> .
*For covered charges related to claims from out-of-network providers, see “Benefit Level Exceptions” later in this <i>Section 3: How Your Plan Works</i> .
*For covered charges related to claims from providers outside New Mexico, see “BlueCard” in <i>Section 8: Claims Payments and Appeals</i> .

PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

When you need medical care, there are a variety of ways you can choose a Primary Preferred Provider (PPP) or other Preferred Provider in your area. You can also access mental health providers (including those specializing in chemical dependency) and participating pharmacies. **Note:** Only those providers listed under Family Practice, General Practice, Oriental Medicine, Internal Medicine, Gynecology, Obstetrics/Gynecology and Pediatrics are considered Primary Preferred Providers (PPPs). See “Cost-Sharing Features,” later in this section for details.

Whichever method you choose, the provider directory gives each provider’s specialty, the language spoken in the office, the office hours, and other information such as whether the office is handicapped accessible. (To find this information on the website directory, click on the doctor’s name once you have found one you want to know more about.) The website directory also gives you a map to the provider’s office.

Note: Providers who are listed in the directory as having a “participating” contract are **not** “preferred” providers (unless they are also listed as having a “preferred” provider contract). **You will not receive the “Preferred Provider” benefit level when receiving services from a “participating” network provider.** You must use providers in the “preferred” provider network in order to obtain the highest level of benefit under this Plan for non-emergency care. However, if you live in or travel to a state that does not offer Preferred Provider contracts, you can receive the “Preferred Provider” benefit level by visiting “participating” providers in that state. **If you are in an emergency situation, call 911 if necessary or go directly to the nearest emergency room.**

Although provider directories are current as of the date shown at the bottom of each page of a printed directory or as of the date an Internet site was last updated, the network and/or a particular provider’s status can change without notice. To verify a provider’s current status, request a current directory, request a paper copy of a directory (free of charge), or if you have any questions about the directory, contact a BCBSNM Customer Service Advocate. It is also a good idea to speak with a provider’s office staff directly to verify whether or not they belong to the BCBS Preferred Provider network before making an appointment.

Web-Based BCBSNM Provider Finder

To find a Preferred Provider in New Mexico or along the border of neighboring states, please visit the *Provider Finder* section of the BCBSNM website for a list of network providers:

www.bcbsnm.com

The website is the most up-to-date resource for finding providers and also has an Internet link to the national Blue Cross and Blue Shield Association website for services outside New Mexico. Website directories also include maps and directions to provider locations.

Paper Provider Network Directory

If you want a paper copy of a *BCBSNM Preferred Provider Network Directory*, you may request one from BCBSNM Customer Service and it will be mailed to you free of charge. You may also call BCBSNM and request a paper copy of a BCBS provider directory from another state.

Finding a Pharmacy

To find a participating pharmacy, visit the Prime Therapeutics website at:

www.MyPrime.com

Click on *Find a Pharmacy*. You will then be asked to select from a list of BCBS Plans. **You must select “Blue Cross and Blue Shield of New Mexico”** and then select **“Other BCBSNM Plans”** in order to get the correct list of participating pharmacies for this health plan. After you have selected “Blue Cross and Blue Shield of New Mexico” as your health plan administrator, you will be able to locate participating pharmacies throughout the United States based on zip code or state name. You may also request a paper copy of the list of participating pharmacies by calling a Customer Service Advocate at BCBSNM.

Providers Outside New Mexico

Out-of-state providers that contract with their local Blue Cross and/or Blue Shield Plan and international providers that contract with the Blue Cross and Blue Shield Association as **Preferred Providers** are also eligible for the “Preferred Provider” level of benefits for covered services, including fixed-dollar copayment amounts listed on the *Summary of Benefits*. **Note:** Providers who have a “Participating Provider-only” contract are **not** Preferred Providers and you will not receive the Preferred Provider benefit level when receiving services from participating-only providers. You must use **Preferred Providers** in order to obtain the higher benefit (unless listed under **“Benefit Level Exceptions,”** later in this section).

You have a number of ways to locate a Preferred Provider in the United States or around the world:

BCBSNM Website

If you have an Internet connection, go to the BCBSNM website at www.bcbsnm.com, click on “Provider Finder[®]” and then select the line entitled “Providers located outside New Mexico.” You will then be linked to the Blue Cross Blue Shield Association’s BlueCard Doctor and Hospital Finder.

BCBSNM website: www.bcbsnm.com

National Website

Visit the Blue Cross and Blue Shield Association website at www.bcbs.com and click on the national “BlueCard Doctor and Hospital Finder,” then select “Find a Doctor or Hospital.” Follow the instructions.

Blue Cross and Blue Shield Association website:

www.bcbs.com (or www.bluecares.com)

National Phone Number

Call BlueCard Access[®] at the phone number below for the names and addresses of doctors and hospitals in the area where you or an eligible family member need care. When you call, a BlueCard representative will give you the name and telephone number of a local provider (you will be asked for the zip code in the area of your search)

who will be able to call Customer Service for eligibility information and will submit a claim for the services provided to the local BCBS Plan. Call:

1-800-810-BLUE (2583)

International Assistance

Call the service center at one of the phone numbers below, 24 hours a day, 7 days a week, for information on doctors, hospitals, and other health care professionals or to receive medical assistance services around the world. An assistance coordinator, in conjunction with a medical professional, will help arrange a doctor's appointment or hospitalization, if necessary. If you need to be hospitalized, call BCBSNM for preauthorization. You can find the preauthorization phone number on your ID card. **Note:** The phone number for preauthorization is different from the following phone numbers, which are strictly for locating a Preferred Provider while outside the United States:

1-800-810-BLUE (2583) or call collect: 1-804-673-1177

CALENDAR YEAR

A Calendar Year is a period of one year which begins on January 1 and ends on December 31 of the same year. The initial Calendar Year is from a member's effective date of coverage through December 31 of the same year, which may be less than 12 months.

BENEFIT LIMITS

There is no general lifetime maximum benefit under this Plan. However, certain services have separate benefit limits per admission or per Calendar Year. (See the *Summary of Benefits* for details.)

Benefits are determined based upon the coverage in effect on the day a service is received, an item is purchased, or a health care expense is incurred. For inpatient services, benefits are based upon the coverage in effect on the date of admission, except that if you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

COST-SHARING FEATURES

For some services, you will pay only a fixed-dollar amount copayment for covered charges. In other cases, you will have to meet a deductible and pay a percentage of the covered charge (Preferred Providers will not bill you for amounts in excess of the covered charge). When you receive a number of services during a single visit or procedure, you may have to pay both a copayment and a deductible (if applicable) plus a percentage of the covered charges that are not included in the copayment. Refer to your Summary of Benefits for details.

YOUR DEDUCTIBLE

Your deductible is the amount of covered charges that you must pay in a Calendar Year before this Plan begins to pay its share of the applicable (preferred or Nonpreferred Provider) covered charges you incur during the same Calendar Year. If the deductible amount remains the same during the Calendar Year, you pay it only once each Calendar Year, and it applies to all preferred or Nonpreferred Provider covered services you receive during that Calendar Year.

Individual Deductible

There are **two** individual deductible amounts indicated on your *Summary of Benefits*. Once a member's deductible payments for Preferred Provider services reach the individual Preferred Provider deductible amount, this Plan will begin paying its share of that member's covered Preferred Provider charges. The member must meet the higher Nonpreferred Provider deductible before this Plan begins to pay its share of his/her covered charges from Nonpreferred Providers.

Covered charges for Preferred Provider services are **not** applied to the Nonpreferred Provider deductible and covered charges for Nonpreferred Providers are **not** applied to the Preferred Provider deductible.

Family Deductible

An entire family meets the applicable annual deductible when the total deductible amount for all family members reaches the amount specified on your separately issued *Summary of Benefits*. **Note:** If a member's deductible is met, no more charges incurred by that member may be used to satisfy the applicable Family deductible.

What Is Not Subject to the Deductible

The following are not applied to the annual deductible:

- charges covered under your *Drug Plan Rider*
- Preferred Provider copayments
- preventive services when received from a Preferred Provider
- hearing aids and ear molds for members under the age of 21

Admissions Spanning Two Calendar Years

If a deductible has been met while you are an inpatient and the admission continues into a new Calendar Year, no additional deductible is applied to that admission's covered services. However, all other services of a Nonpreferred Provider, while the admission continues, that received during the new Calendar Year are subject to the deductibles for the new Calendar Year.

Timely Filing Reminder

Most benefits are payable only after BCBSNM's records show that the applicable deductible has been met. Preferred Providers and providers that have "participating-only" provider agreements with BCBSNM will file claims for you and must submit them within a specified amount of time (usually 180 days). If you file your own claims for covered services from Nonparticipating Providers, you must file them **within 12 months** of the date of service. If a claim is returned for further information, resubmit it **within 45 days**. See *Section 8: Claim Payments and Appeals* for details.

COPAYMENTS

When you visit a Preferred Provider in his/her office, the office visit charge is subject to the PPP office visit copayment described below. Other services received during the visit, services of other Preferred Providers, and the services of Nonpreferred Providers are subject to the deductible, coinsurance, and out-of-pocket limit provisions described below.

Office Visit Copayment

When you receive **office services** from a Preferred Provider, you pay only a fixed-dollar amount (or copayment), for his/her covered **office visit charge**. The copayments for "Primary Preferred Provider" (PPP) and PPO Specialist office visits are listed on the *Summary of Benefits*. However, all other services received during the office visit (such as physical therapy or chemotherapy) will be subject to regular deductible and/or coinsurance requirements and/or to an additional Copayment as listed on the *Summary of Benefits*.

Primary Preferred Provider (PPP) is a Preferred Provider in one of the following medical specialties **only**: Family Practice; General Practice; Oriental Medicine; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not** include physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery or Pediatric Allergy.

Preferred (PPO) Specialist is a practitioner of the healing arts who is in the Preferred Provider Network – but does not belong to one of the specialties defined above as being for a "Primary Preferred Provider" (or "PPP"). A PPO Specialist does not include hospitals or other treatment facilities, urgent care facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary health care providers.

Drug Plan Copayment

When you purchase covered prescription drugs and other items through the drug plan, your responsibility may be either a fixed-dollar amount or a percentage of the covered charge. (You may also have to pay the difference between the cost of a brand-name drug and its generic equivalent.) In either case, drug plan copayments are not

subject to the Deductible or Out-of-pocket limit provisions. See your Drug Plan Rider for more information about the drug plan.

COINSURANCE

For some covered services, received from Nonpreferred Providers (and for specified services received from Preferred Providers) you must pay a percentage of covered charges (coinsurance) after you have met your annual deductible. After your share has been calculated, this Plan pays the rest of the covered charge, up to maximum benefit limits, if any. You pay a lower percentage of covered charges when you visit a Preferred Provider.

Nonpreferred Providers may charge you the difference between the billed charge for a covered service and the covered charge allowed by BCBSNM – in addition to your coinsurance and deductible amount.

Remember: The covered charge may be less than the billed charge for a covered service. Preferred Providers may not bill you more than the covered charge. **Note:** If you receive covered services from an “unsolicited” provider, as defined in this section, you will be responsible for amounts over the covered charge.

Preferred Providers

When you receive covered services from a Preferred Provider, you pay an annual deductible and, after meeting the deductible, you pay a percentage of covered charges (coinsurance). Preferred Provider office visit charges are not subject to the coinsurance or deductible unless listed as otherwise on your summary. Other services of a Preferred Provider and services of a Nonpreferred Provider **are** subject to deductible and coinsurance.

Nonpreferred Providers

When you receive covered services from a Nonpreferred Provider, you have a higher deductible amount to meet each year and you must pay a higher percentage of covered charges for Nonpreferred Provider services. If the covered charge is less than the billed charge, you will also be responsible for paying the difference when you receive services from a Nonpreferred Provider. See *Section 8: Claims and Appeals*, “Provider Payment Example,” for more information.

OUT-OF-POCKET LIMIT

The out-of-pocket limit is the maximum amount of deductible, coinsurance, and copayments that you pay for most covered services in a Calendar Year. There are separate out-of-pocket limits for Preferred Providers and Nonpreferred Providers. After the out-of-pocket limit is reached, this Plan pays 100 percent of most of your Preferred Provider or Nonpreferred Provider covered charges for the rest of the Calendar Year, not to exceed any benefit limits.

The out-of-pocket amounts for Preferred Provider services are **not** applied to the Nonpreferred Provider out-of-pocket limit. In addition, the out-of-pocket amounts for Nonpreferred Provider services are not applied to the Preferred Provider out-of-pocket limit.

Individual Limits

Once your coinsurance amounts for Preferred Provider services in a Calendar Year reaches the individual Preferred Provider amount indicated on the *Summary of Benefits*, this Plan pays 100 percent of most of your covered Preferred Provider charges for the rest of the Calendar Year.

Once your coinsurance amounts for Nonpreferred Provider services in a Calendar Year reaches the higher individual Nonpreferred Provider amount indicated on the *Summary of Benefits*, this Plan pays 100 percent of most of your covered Nonpreferred Provider charges for the rest of the Calendar Year.

Family Limits

An entire family meets the out-of-pocket limit during a Calendar Year when the total deductible, coinsurance and copayments for all family members reaches the amount specified in the *Summary of Benefits*. (When a member meets the Individual out-of-pocket limit, no more charges incurred by that member may be used to satisfy the Family out-of-pocket limit.) The deductible, coinsurance and copayments for the **remaining** family members are combined to satisfy the family out-of-pocket.

What Is Not Included in the Out-of-Pocket Limits

The following amounts are **not** applied to the out-of-pocket limits and are **not** eligible for 100 percent payment under this provision:

- penalty amounts
- amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits, if applicable)
- Preferred Provider office visit copayments
- deductible amounts
- noncovered expenses (including services in excess of annual or lifetime day/visit limits)
- drug plan copayments and/or coinsurance amounts
- expenses covered under the “Heart, Heart–Lung, Liver Lung, Pancreas–Kidney” transplant provisions (there is a separate \$5,000, out-of-pocket limit for certain transplant services. See Transplant Services in *Section 5: Covered Services* section for details.)

See the Summary of Benefits for your deductible amounts, coinsurance percentages and out-of-pocket limit amounts.

CHANGES TO THE COST-SHARING AMOUNTS

Copayments, coinsurance percentage amounts, deductibles, and out-of-pocket limits may change during a Calendar Year. If changes are made, the change applies only to services received after the change goes into effect (for inpatient services, benefits are determined based on the date you are admitted to the facility). You will be notified if changes are made to this Plan. If any benefit changes result in a premium increase, you will be given 60 days’ notice of such changes.

If your group increases the deductible or out-of-pocket limit amounts during a Calendar Year, the new amounts must be met during the same Calendar Year. For example, if you have met your deductible and your group changes to a higher deductible, you will not receive benefit payments for services received after the change went into effect until the increased deductible is met.

If you must change from Individual Coverage to Family Coverage because you must add an eligible family member to your coverage, you and your new eligible family member must meet the higher Family Coverage deductible and out-of-pocket limit. **Exception:** If you must switch to Family Coverage because of adding an eligible newborn child within the time limits specified in *Enrollment and Termination*, you will not be required to meet the Family Coverage deductible and out-of-pocket limits for covered hospital services related to routine newborn nursery care. However, the newborn’s pediatrician services for routine newborn care *will* be subject to Family Coverage deductible and out-of-pocket provisions.

If you lose an eligible family member and must switch from Family to Individual Coverage, you will be given credit for all amounts applied to both the Family Coverage deductible and the Family Coverage out-of-pocket limit. However, you will not be given a refund for any amounts that are in excess of the new individual coverage amount.

If your employer provided a choice of **two or more** benefit plan options and you wish to change to a lower or higher deductible (and out-of-pocket limit), you may do so only during your group’s annual renewal period.

BENEFIT LEVEL EXCEPTIONS

Benefits will be provided as indicated on the *Summary of Benefits*, except as listed below.

Emergency Care

If you visit a Nonpreferred Provider for emergency care services, the Preferred Provider deductible and coinsurance is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. (Office/urgent care facility services are not considered “emergency care” for purposes of this provision.)

For follow-up care (which is no longer considered emergency care) and for all other non-emergency care, you will receive the Nonpreferred Provider benefit for the services of a Nonpreferred Provider, even if a Preferred Provider is not available to perform the service, except as specified below. (See “Emergency and Urgent Care” in *Section 5: Covered Services* for more information.)

Transition of Care

This provision applies to both Continuity of Care and Transition of Care. If your health care provider leaves the BCBSNM provider network (for reasons other than medical competence or professional behavior) or if you are a new member and your provider is not in the provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating provider, BCBSNM may also authorize transitional care from other out-of-network providers.) An ongoing course of treatment will include, but is not limited to: (1) Treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) Treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (3) The second or third trimester of pregnancy, through the postpartum period; or (4) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes. The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. Call the BCBSNM Customer Service department for details.

Members who extend coverage under an extension of benefits due to disability after the group contract is terminated are not eligible to receive preauthorization for services of an out-of-network provider. Services of an out-of-network provider are **not** covered at the in-network level (if any) in such instances of extended coverage.

Unsolicited Providers

In some states, the local BCBS Plan does not offer Preferred Provider contracts to certain types of providers (e.g., home health care agencies, chiropractors, ambulance providers). These provider types are referred to as “unsolicited providers.” Unsolicited providers vary from state to state. If you receive covered services from an “unsolicited provider” outside New Mexico, you will receive the Preferred Provider benefit level for those services. However, the unsolicited provider may still bill you for amounts that are in excess of covered charges. You will be responsible for these amounts, in addition to your deductible and coinsurance.

Ancillary Provider

Once you have obtained preauthorization for an inpatient admission to a preferred hospital or treatment facility, your preferred physician or hospital will make every effort to ensure that you receive ancillary services from other Preferred Providers. If you receive covered services from a **preferred** physician for outpatient surgery or inpatient medical/surgical care in a preferred hospital or treatment facility, services of a nonpreferred radiologist, anesthesiologist, or pathologist will be paid at the Preferred Provider level and you will not be responsible for any amounts over the covered charge (these are the only three specialties covered under this provision).

If a **nonpreferred** surgeon provides your care or you are admitted to a nonpreferred hospital or other treatment facility, you **will** be responsible for amounts over the covered charge for any services received from Nonpreferred Providers during the admission or procedure.

Note: Except as described above, the Preferred Provider benefit level will not apply to non-emergency services when received from a Nonpreferred Provider.

SECTION 4: PREAUTHORIZATIONS

Preauthorizations are a requirement that you or your Provider must obtain authorization from BCBSNM before you are admitted as an inpatient or receive certain types of services.

In order to receive benefits:

- services must be covered and Medically Necessary;
- services must not be excluded; and
- the procedures described in this section must be followed regardless of where services are rendered or by whom.

Preauthorization determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. Preauthorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive benefits. Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this Plan, and services that are not Medically Necessary will be denied.

Medically Necessary/Medical Necessity is defined as Health Care Services that BCBSNM determines a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Hospital, Physician, or other Provider, and not more costly, as determined by BCBSNM or its agents, than an alternative clinical service, therapy, or procedure or sequence of services, therapies, and procedures that based on evidence-based clinical data are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Please note:

Preauthorization is a requirement that you or your Provider must obtain authorization from BCBSNM before you are admitted as an inpatient and before you receive certain types of services.

Even when this Plan is not your primary coverage, these Preauthorization procedures must be followed. Failure to do so may result in a reduction or in a denial of benefits.

Most Preauthorization requests will be evaluated and you and/or the Provider notified of BCBSNM's decision **within 5 days** of receiving the request (within 24 hours for Urgent Care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see **Section 8: Claims Payments and Appeals**) and "If Your Preauthorization Request is Denied" later in this section.

Retroactive approvals will not be given, except for Emergency and Maternity- related Admissions, and you may be responsible for the charges if Preauthorization is not obtained before the service is received.

HOW THE PREAUTHORIZATION PROCEDURE WORKS

When you or your Provider call, BCBSNM's Health Services representative will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay (if you are being admitted). The Health Services representative will evaluate the information and notify the requesting Provider (usually at the time of the call) if benefits for the proposed hospitalization or other services are preauthorized. If the Admission or other services are not preauthorized, you may appeal the decision as explained in **Section 8: Claims Payments and Appeals**.

BCBSNM PREFERRED PROVIDERS IN NEW MEXICO

If the attending Physician is a Preferred Provider that contracts directly with BCBSNM, obtaining Preauthorization is not your responsibility — it is the Provider’s. Preferred Providers must obtain Preauthorization from BCBSNM (or from the Behavioral Health Unit (BHU), when applicable) in the following circumstances:

- when recommending any non-Emergency Admission, re-Admission, or transfer
- when a covered newborn stays in the Hospital longer than the mother
- before providing or recommending a service listed under “Other Preauthorizations,” later in this section
- before recommending that you go to a Nonpreferred Provider for whose services you expect to receive benefits (Such requests may be denied.)

BCBSNM will advise you if a Preauthorization request is denied.

Note: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the Preauthorization requirements of BCBSNM. Unless a Provider contracts directly with BCBSNM as a Preferred Provider, the Provider is not responsible for being aware of this Plan’s Preauthorization requirements.

NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

If any Provider outside New Mexico (except for those contracting as Preferred Providers directly with BCBSNM) or any Nonpreferred Provider recommends an Admission or a service that requires Preauthorization, the Provider is not obligated to obtain the Preauthorization for you. In such cases, it is your responsibility to ensure that Preauthorization is obtained. If authorization is not obtained before services are received, **you may** be entirely responsible for the charges. The Provider may call on your behalf, but it is your responsibility to ensure that BCBSNM is called.

INPATIENT PREAUTHORIZATION

Preauthorization is required for all Admissions before you are admitted to the Hospital or other inpatient treatment Facility (e.g., Skilled Nursing Facility, Residential Treatment Center, physical rehabilitation Facility, long-term acute care (LTAC). If you are receiving services at an out-of-network Facility (or from an in-network Facility outside New Mexico) and you do not obtain authorization within the time limits indicated in the table below, benefits for covered Facility services will be reduced or denied as explained under “*Not Obtaining Inpatient Preauthorization*” below.

Type of inpatient Admission, re-Admission, or transfer:	When to obtain inpatient Admission Preauthorization:
Non-Emergency	Before the patient is admitted.
Emergency, non-Maternity	Within 48 hours of the Admission. If the patient’s condition makes it impossible to call within 48 hours, call as soon as possible.
Maternity-related (including eligible newborns when the mother is not covered)	Before the mother’s Maternity due date, soon after pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother’s stay is greater than 48 hours for a routine delivery or greater than 96 hours for a C-section delivery.
Extended stay, newborn (an eligible newborn stays in the Hospital longer than the mother)	Before the newborn’s mother is discharged.

NOT OBTAINING INPATIENT PREAUTHORIZATION

If you or your Provider do not receive Preauthorization for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid as indicated in the table below:

If, based on a review of the Claim:	Then:
The Admission was not for a Covered Service.	Benefits for the Facility and all related services will be denied.*
The Admission was for an item listed under “Other Preauthorizations,” (e.g., elective admissions).	Benefits for the Facility and all related services may be denied.*

The Admission was for any other Covered Service but hospitalization was not Medically Necessary.	Benefits may be denied for room, board, and other charges that are not Medically Necessary.*
The Admission was for a Medically Necessary Covered Service.	Benefits for the Facility's Covered Services may be denied. *

*The admission review penalty of **\$300** and charges for noncovered and denied services are **not applied** to any deductible or out-of-pocket limit. You are responsible for paying this amount for out-of-network services.

Inpatient Preauthorization requirements may affect the amounts that this Plan pays for Inpatient Services, but they do not deny your right to be admitted to any Facility and to choose your services.

OTHER PREAUTHORIZATIONS

In addition to Preauthorization review for all non-Emergency Inpatient Services, Preauthorization is required for certain other services listed below. Most Preauthorizations may be requested over the telephone. If a *written* request is needed, have your Provider call a Health Services representative for instructions for filing a written request for Preauthorization. An out-of-network Provider, or an out-of-state Network Provider may call on your behalf, but it is your responsibility to ensure that BCBSNM is called. Preferred Providers that contract directly with BCBSNM are responsible for requesting all necessary Preauthorizations for you. (See “*Inpatient Preauthorization*” (or similar heading) for further information regarding inpatient Preauthorization requirements.)

If Preauthorization is not obtained for the following services and any related services, the service will be reviewed for Medical Necessity and subject to one of the following actions in the chart below:

No Preauthorization Received:	Claim Disposition: Preferred	Claim Disposition: Nonpreferred
Service is Medically Necessary	Claim is paid based on Member's benefit plan	Claim is paid based on Member's benefit plan
Service is not Medically Necessary	Claim is denied; Member is held harmless	Claim is denied

Services that require Preauthorization:

- All inpatient Hospital Admissions
- The following Outpatient Services and procedures:
 - Home Health Care Services and home I.V. services
 - home infusion therapy (HIT), excluding antibiotics
 - home hemodialysis
 - home Hospice services
 - Radiation Therapy
 - transitional care benefits
 - Dialysis for out-of-network services only
 - certain injections, including but not limited to intravenous immunoglobulin (IVIG)
 - molecular genetic testing
 - Outpatient Surgery performed at a Hospital or Ambulatory Surgical Facility for out-of-network services only
 - Transplant Procedures including pre-transplant evaluations
 - **Ear, Nose and Throat (ENT):**
 - Bone Conduction Hearing Aids
 - Cochlear Implant
 - Nasal and Sinus Surgery

- **Gastroenterology (Stomach):**
 - Gastric Electrical Stimulation (GES)
- **Neurological:**
 - Deep Brain Stimulation
 - Sacral Nerve Neuromodulation/Stimulation
 - Vagus Nerve Stimulation (VNS)
- **Orthopedic Musculoskeletal:**
 - Artificial Intervertebral Disc
 - Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions
 - Femoroacetabular Impingement (FAI) Syndrome
 - Functional Neuromuscular Electrical Stimulation (FNMES)
 - Joint and Spine Surgery
 - Lumbar Spinal Fusion
 - Meniscal Allografts and Other Meniscal Implants
 - Orthopedic Applications of Stem-Cell Therapy
- **Pain Management:**
 - Occipital Nerve Stimulation
 - Surgical Deactivation of Headache Trigger Sites
 - Interventional Pain Management
 - Percutaneous and Implanted Nerve Stimulation and Neuromodulation
 - Spinal Cord Stimulation
- **Radiology:**
 - Advanced Imaging Services-CT, CTA, MRI, MRA, PET, PET/CT, and Nuclear Medicine (excludes Cardiac Advanced Imaging)
- **Sleep Medicine:**
 - Sleep Study (Facility based polysomnography/pap titration)
- **Surgical Procedures:**
 - Orthognathic Surgery
 - Mastopexy
 - Reduction Mammoplasty; Breast Reduction
- **Wound Care:**
 - Hyperbaric Oxygen (HBO2) Therapy

For specific details about the Preauthorization requirement for the above referenced Outpatient Services, please call Customer Service at the number on the back of your Identification Card. BCBSNM reserves the right to no longer require Preauthorization during the Calendar Year. Updates to the list of services requiring Preauthorization may be confirmed by calling Customer Service.

All services, including those for which Preauthorization is required, must meet the standards of Medical Necessity criteria described in **Section 5: Covered Services**, “Medically Necessary Services,” and will not be covered, if excluded, for any reason. Some services requiring Preauthorization may not be approved for payment (for example, due to being Experimental, Investigational or Unproven, or not Medically Necessary). Services requiring Preauthorization are subject to review and change by BCBSNM.

The Preauthorization requirements noted above do not apply to mandated benefits, unless permitted by law and stated in the provisions of a specific mandated benefit. The Medical Necessity requirements noted above do not apply to mandated benefits, unless permitted by law.

It is strongly recommended that you request a Predetermination for benefits for high-cost services in order to reduce the likelihood of benefits being denied after charges are incurred. See “Advance Benefit Information/Predetermination” later in this section for further information.

PREAUTHORIZATION OF MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES

All inpatient mental health and Chemical Dependency services must be preauthorized by the BCBSNM Behavioral Health Unit (BHU) at the phone number listed on the back of your ID Card. Preauthorization is also required for the following Outpatient Services for treatment of Mental Disorder and/or Chemical Dependency:

- psychological testing
- neuropsychological testing
- Intensive Outpatient Program (IOP) treatment
- electroconvulsive therapy (ECT)
- repetitive transcranial magnetic stimulation
- Applied Behavior Analysis (ABA) therapies

Preauthorization is not required for group, individual, or family therapy outpatient office visits to a Physician or other Professional Provider licensed to perform Covered Services under this health plan.

For services needing Preauthorization, you or your health care Provider should call the BHU before you schedule treatment. **NOTE:** Your Provider may be asked to submit clinical information in order to obtain Preauthorization for the services you are planning to receive. Services may be authorized or may be denied based on the clinical information received. (*Clinical information* is information based on actual observation and treatment of a particular patient.)

If you or your Provider do not call for Preauthorization of non-Emergency Inpatient Services, benefits for covered, Medically Necessary inpatient Facility care may be denied. If Inpatient Services received without Preauthorization are determined to be not Medically Necessary or not eligible for coverage under your Plan for any other reason, the Admission and all related services will be denied. In such cases, you may be responsible for all charges.

If Preauthorization is not obtained before you receive psychological testing, IOP treatment, neuropsychological testing, electroconvulsive therapy repetitive transcranial magnetic stimulation or Applied Behavior Analysis (ABA) therapies, your Claims may be denied if it is not Medically Necessary. In such cases, you may be responsible for all charges. Therefore, you should make sure that you (or your Provider) have obtained Preauthorization for Outpatient Services before you start treatment.

Use the chart below to determine the appropriate contact for your situation.

Summary of Contact Information for Preauthorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:			
Process:	Type of Service:	Phone:	Send to:
Request preauthorization	Medical/surgical	1-800-325-8334	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit P.O. Box 27630, Albuquerque, NM 87125-7630
Customer Service Inquiry	Medical/surgical	1-866-369-NMSU (6678)	BCBSNM, P.O. Box 27630, Albuquerque, NM 87125-7630
	Mental health/chemical dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Submit claim (post-service)	Medical/surgical		BCBSNM, P.O. Box 27630, Albuquerque, NM 87125-7630
	Mental health/chemical dependency		BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Request appeal or reconsideration of claim or preauthorization decision	Medical/surgical	1-800-205-9926	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental health/chemical dependency	1-888-898-0070	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Grievance Assistance - Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/surgical; Mental health/chemical dependency	1-855-427-5674	OSI P.O. Box 1689 Santa Fe, NM 87504-1689

IF YOUR PREAUTHORIZATION REQUEST IS DENIED

BCBSNM has established written procedures for reviewing and resolving your concerns. There are two different procedures depending upon the type of issue involved - pre-service or post-service. This is a summary of the procedures that apply to Preauthorization requests ("pre-service Claims"). For appeals involving post-service Claims payments or denials, see *Section 8: Claims Payment and Appeals*.

If you are dissatisfied at any time during the process described below, you may file an appeal. You may designate a representative to act for you in the review and appeal procedures. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. If you make an inquiry or request an appeal under the following procedures, you will not be subject to retaliatory action by BCBSNM.

If you have an inquiry or a concern about any Preauthorization request, call your Customer Service Advocate for assistance. Many complaints or problems can be handled informally by calling or writing BCBSNM Customer Service. If you make an oral complaint, a BCBSNM Customer Service Advocate will assist you.

ADVANCE BENEFIT INFORMATION/PREDETERMINATION

If you want to know what benefits will be paid before receiving services or filing a Claim, BCBSNM may require a written request. BCBSNM may also require additional information and a written statement from the Provider identifying the circumstances of the case and the specific services that will be provided. An advance confirmation/Predetermination of benefits does not guarantee benefits if the actual circumstances of the case differ from those originally described. When submitted, Claims are reviewed according to the terms of this Benefit Booklet, your eligibility, or any other coverage that applies on the date of service.

UTILIZATION REVIEW/QUALITY MANAGEMENT

Medical records, Claims, and requests for Covered Services may be reviewed to establish that the services are/were Medically Necessary, delivered in the appropriate setting, and consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of BCBSNM's professional consultants. Utilization Management decisions are based only on appropriateness of care and service. BCBSNM does not reward Providers or other individuals conducting utilization review for denying coverage or services and does not offer incentives to utilization review decision-makers to encourage underutilization.

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this health care plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on covered charges as determined by BCBSNM.

Reminder: It is to your financial advantage to receive care from Preferred Providers

MEDICALLY NECESSARY SERVICES

A service or supply is Medically Necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this Plan, and is determined by BCBSNM's medical director (in consultation with your provider) to meet the following definition:

Medically Necessary is defined as Health Care Services that BCBSNM determines a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Hospital, Physician, or other Provider, and not more costly, as determined by BCBSNM or its agents, than an alternative clinical service, therapy, or procedure or sequence of services, therapies, and procedures that based on evidence-based clinical data are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

All services must be eligible for benefits as described in this section, not listed as an exclusion and/or meet all of the conditions of Medically Necessary as defined above in order to be covered.

Note: Because a health care Provider prescribes, orders, recommends, or approves a service does not make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion. BCBSNM will determine Medical Necessity based on the criteria above.

Preauthorizations are a requirement that you or your Provider must obtain authorization from BCBSNM before you are admitted as an inpatient or receive certain types of services.

In order to receive benefits:

- services must be covered and Medically Necessary;
- services must not be excluded; and
- the procedures described in this section must be followed regardless of where services are rendered or by whom.

Preauthorization determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. **Preauthorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive benefits.** Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this Plan, and services not Medically Necessary will be denied.

AMBULANCE SERVICES

This Plan covers ambulance services in an emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a non-emergency situation, this Plan also covers Medically Necessary ambulance transportation to a hospital with appropriate facilities, or from one hospital to another.

Air Ambulance

Ground ambulance is usually the approved method of transportation. This Plan covers air ambulance only when terrain, distance, or your physical condition requires the use of air ambulance services or for high-risk maternity and newborn transport to tertiary care facilities. To be covered, non-emergency air ambulance services require **preauthorization** from BCBSNM.

Exclusions

This Plan does **not** cover:

- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance
- services ordered only because other transportation was not available, or for your convenience

AUTISM SPECTRUM DISORDERS

For a member **19 years old or younger** (or, if enrolled in high school, 22 years old or younger), this Plan covers the habilitative and Rehabilitative Services of Autism Spectrum Disorder through speech therapy, occupational therapy, physical therapy, and Applied Behavioral Analysis (ABA). Providers must be credentialed to provide such therapy. Note: ABA services are not indicated for children over the age of seven.

Treatment must be prescribed by the member's treating physician in accordance with a treatment plan. The **treatment plan** must be **preauthorized** by BCBSNM to determine that the services are to be performed in accordance with such a treatment plan; if services are received but were not approved as part of the treatment plan, benefits for services will be denied.

Services not preauthorized by BCBSNM must be performed in accordance with a treatment plan and must be medically necessary or benefits for such services will be denied. **Note:** Habilitative services are defined as Occupational Therapy, Physical Therapy, Speech Therapy and other health care services that help you keep, learn, or improve skills and functioning for daily living, as prescribed by your Physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Policy.

Benefits for all services for the treatment of autism spectrum disorder are limited for each eligible BCBSNM insured person to \$36,000 per Calendar Year and to \$200,000 in total lifetime benefits. Once the annual maximum is reached, no more benefits for autism therapy are provided until the next year. Once a lifetime maximum is reached, no more benefits for autism therapy are provided for that BCBSNM member. Changing from one plan to another under the same group, reinstating prior BCBSNM coverage, changing employers, changing policy holder or subscriber, or moving from individual coverage to group coverage or vice versa does not reinstate autism benefits once an annual or lifetime maximum is reached for a particular insured member. All amounts payable under this provision are tracked at the member level regardless of the policy number under which charges accrued. For example, if a member is covered under two BCBSNM policies, the maximum annual benefit and the maximum lifetime benefit is not doubled for that member. Regardless of the number of policies under which the member is covered, benefits will not exceed the per member annual and lifetime maximum benefits mandated by law.

Services are subject to usual member cost-sharing features such as deductible, coinsurance, copayments, and out-of-pocket limits - based on place of treatment and type of service. All services are subject to the *General Limitations and Exclusions* except where explicitly mentioned as being an exception. This benefit is subject to the other general provisions of the Plan, including but not limited to: coordination of benefits, Participating Provider agreements, restrictions on health care services, including review of medical necessity, case management, and other managed care provisions.

Regardless of the type of therapy received, claims for services related to Autism Spectrum Disorder should be mailed to BCBSNM - **not** to the behavioral health services administrator.

Exclusions

This Plan does **not** cover:

- any experimental, long-term, or maintenance treatments not required under state law
- Services that are not Medically Necessary
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have Autism Spectrum Disorder
- services in accordance with a treatment plan that has not been Preauthorized by BCBSNM
- respite services or care
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- music therapy, vision therapy, or touch or massage therapy
- floor time
- communication
- elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- chelation therapy
- hippotherapy, animal therapy, or art therapy

DENTAL-RELATED SERVICES AND ORAL SURGERY

The following services are the only dental-related services and oral surgery procedures covered under this Plan. When alternative procedures or devices are available, benefits are based upon the most cost-effective, medically appropriate procedure or device available.

Dental and Facial Accidents

Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face or sound natural teeth are generally subject to the same limitations, exclusions and member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, medical supplies, surgical services). This also includes services or supplies provided for the treatment of an Accident Injury resulting from an act of domestic violence or a medical condition.

To be covered, *initial* treatment for the accidental injury should be sought as soon as possible after an accident to minimize any adverse effects that may occur due to lack of appropriate medical attention. Any services required after the initial treatment must be associated with the initial accident in order to be covered. (For treatment of TMJ or CMJ injuries, see “TMJ/CMJ Services.”)

Facility Charges and General Anesthesia for Dental-Related Services

This Plan covers inpatient or outpatient Hospital expenses (including Ambulatory Surgical Facilities) and Hospital and Physician charges for the administration of general anesthesia for noncovered, Medically Necessary Dental-Related Services if the patient requires hospitalization for one of the following reasons:

- Because of the **patient’s** physical, intellectual or medical condition(s), local anesthesia is not the best choice.
- Local anesthesia is ineffective because of acute infection, anatomic variation, or allergy to local anesthesia.
- The patient is a member age 19 or younger who is extremely uncooperative, fearful or uncommunicative; his/her dental needs are too significant to be postponed; and lack of treatment would be detrimental to the child’s dental health.
- Because oral-facial or dental trauma is so extensive, local anesthesia would be ineffective.

- There is a medically necessary dental procedure – not excluded by any general limitation or exclusion listed in this benefit booklet such as for work-related or cosmetic services, etc. – that requires the patient to undergo general anesthesia or be hospitalized.

All hospital covered services for dental procedures must be **preauthorized** by BCBSNM. **Note:** Unless listed as a covered service in this section, the dentist’s services for the procedure will not be covered. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Reminder: If hospital covered services are recommended by a nonpreferred (out-of-network) provider, you are responsible for assuring that your provider obtains preauthorization for outpatient covered services or benefits may be denied. (See Section 4: Preauthorizations.)

Oral Surgery

This Plan covers the following oral surgical procedures only:

- Medically Necessary orthognathic surgery
- external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- incision of accessory sinuses, salivary glands or ducts
- lingual frenectomy
- removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of mouth when pathological examination is required

TMJ/CMJ Services

This Plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders or accidental injuries. Treatment may include orthodontic appliances and treatment, crowns, bridges, or dentures **only if** required because of an accidental injury to sound natural teeth involving the temporomandibular or craniomandibular joint.

Exclusions

This Plan does **not** cover oral or dental procedures not specifically listed as covered, such as, but not limited to:

- surgeon’s or dentist’s charges for noncovered dental services
- hospitalization or general anesthesia for the patient’s or provider’s convenience
- any service related to a dental procedure that is not Medically Necessary
- any service related to a dental procedure that is excluded under this Plan for reasons other than being dental-related, even if hospitalization and/or general anesthesia is Medically Necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, work-related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- dental-related services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy)
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, noncovered services, or preparing the mouth for dentures
- duplicate or “spare” appliances
- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an accidental injury and covered under “Dental and Facial Accidents” or “TMJ/CMJ Services”
- dentures, artificial devices and/or bone grafts for denture wear, including implants

DIABETIC SERVICES

Diabetic persons are entitled to the same benefits for Medically Necessary Covered Services as are other members under this Plan. For special coverage details, such as for insulin, glucose monitors and educational services, refer to the applicable provisions as noted below. **Note:** This Plan will also cover items not specifically listed as covered when new and improved equipment, appliances and prescription drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration.

Diabetes Self-Management Education

This Plan covers diabetes self-management training including if you have elevated blood glucose levels. Training must be prescribed by a health care Provider and given by a certified, registered, or licensed health care professional with recent education in diabetes management. Covered services are limited to:

- Medically Necessary visits upon the diagnosis of diabetes
- visits following a Physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self-management
- visits when re-education or refresher training is prescribed by a health care Provider
- medical nutrition therapy related to diabetes management

Diabetic Supplies and Equipment

This Plan covers the following supplies and equipment for diabetic Members with elevated glucose levels (supplies are not to exceed a **30-day supply** purchased during any 30-day period):

- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps and insulin pump supplies
- blood glucose monitors, including those for the legally blind
- Medically Necessary podiatric Appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications

Reminder: See your *Drug Plan Rider* for additional diabetic supply coverage of the following supplies: insulin, insulin needle and syringes, visual reading urine and ketone strips; lancets and lancet devices; prescriptive oral agents for controlling blood sugar levels; test strips for glucose monitors, and glucagon Emergency kits.

Note: The Plan will also cover items not specifically listed as covered when new and improved equipment, Appliances, and prescription drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration. This Plan will: 1) maintain formulary to provide these resources to individuals with diabetes; and 2) guarantee reimbursement or coverage for the equipment, Appliances, prescription drugs, insulin, or Medical Supplies described in this Benefit Booklet and/or your *Drug Plan Rider* within the limits of this Plan.

EMERGENCY CARE AND URGENT CARE

Acute medical Emergency Care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, the condition must meet the definition of an “Emergency” in order to be covered.

Emergency Care

This Plan covers medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. (In addition, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.) Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Emergency Room Services

Use of an emergency center for non-emergency care is NOT covered. However, services will not be denied if you, in good faith and possessing average knowledge of health and medicine, seek care for what reasonably appears to be an emergency — even if your condition is later determined to be non-emergency.

Acute emergency care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, the condition and treatment must meet the definition of emergency care in order to be covered. Services received in an emergency room that do not meet the definition of emergency care may be reviewed for appropriateness and may be denied.

If you visit a Nonpreferred Provider for emergency care, the Preferred Provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. Once you are discharged, covered follow-up care from a Nonpreferred Provider is paid at the Nonpreferred Provider benefit level (Services received in an office or urgent care facility are not considered emergency care for purposes of this provision.)

Emergency Admission Notification

To ensure that benefits are correctly paid and that an admission you believe is emergency-related will be covered, you or your physician or hospital should notify BCBSNM as soon as reasonably possible following admission.

Follow-Up Care

For all follow-up care (which is no longer considered Emergency Care) and for all other nonemergency Care, you will receive the Nonpreferred Provider benefit for the Covered Services of a Nonpreferred Provider, even if a Preferred Provider is **not** available to perform the service.

Urgent Care

This Plan covers urgent care services, which means Medically Necessary medical or surgical procedures, treatments, or services received for an unforeseen condition that is *not* life-threatening. The condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

Urgent care is covered as any other type of service. However, if services are received in an emergency room or other trauma center, the condition and treatment must meet the definition of emergency care in order to be covered.

HEARING AIDS/RELATED SERVICES FOR CHILDREN UNDER AGE 21

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, **up to a maximum amount of \$2,200 per hearing impaired ear every 36 months** for Members under 21 years old. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period begins 36 months after the first hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date the next hearing aid-related service, whichever length of time is greater.

Benefits for hearing aid-related services payable under this provision are not subject to any deductible or coinsurance amount. Benefits for hearing aid-related services will be provided at **100 percent** of the covered charges. (Other covered services, such as hearing examinations and audiometric testing related to a hearing aid need for members under 21 years old are subject to the usual plan deductible and coinsurance and copayment provisions for office services and diagnostic testing. Benefits for these additional services are not applied to the 36-month maximum benefit available for hearing aids.) **Routine hearing examinations and related services are not covered for members age 21 and older.**

HOME HEALTH CARE/HOME I.V. SERVICES

Conditions and Limitations of Coverage

If you are homebound (unable to receive medical care on an outpatient basis), this Plan covers home health care services and home I.V. services provided under the direction of a physician. Nursing management must be through a home health care agency approved by BCBSNM. A *visit* is one period of home health service of up to four hours.

Preauthorization Required

Before you receive home I.V. therapy, your physician or home health care agency must obtain **preauthorization** from BCBSNM. **This Plan does not cover home I.V. services without preauthorization.**

Covered Services

This Plan covers the following services, subject to the limitations and conditions above, when provided by an approved home health care agency during a covered visit in your home:

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by a speech pathologist or an American Speech and Hearing Association certified therapist
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **preauthorization** is received from BCBSNM (If drugs are not provided by the home health care agency, see your separately issued *Drug Plan Rider*.)
- drugs, medicines, or laboratory services that would have been covered during an inpatient admission
- enteral nutritional supplies (e.g., bags, tubing) (For enteral nutritional formulas, see your separately issued *Drug Plan Rider*.)
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions

This Plan does **not** cover:

- care provided primarily for you or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- private duty nursing

HOSPICE CARE SERVICES

Conditions and Limitations

This Plan covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program **preauthorized** by BCBSNM. If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to BCBSNM. (See definition of a hospice benefit period in *Section 10* for more information.)

If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to BCBSNM. No more than two hospice benefit periods will be approved. Note: An extension of the hospice benefit period does not increase the total amount of benefits payable under this provision.

Preauthorization Required

Before you receive home I.V. therapy, your physician or home health care agency must obtain **preauthorization** from BCBSNM. **This Plan does not cover home I.V. services without preauthorization.**

Covered Services

This Plan covers the following services, subject to the conditions and limitations under the hospice care benefit:

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see “Supplies, Equipment and Prosthetics.”)
- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, see your separately issued *Drug Plan Rider*.)
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training and experience (Such services must be recommended by a physician to help the member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period **not to exceed five continuous days** for **every 60 days** of hospice care and **no more than two respite care periods** during each hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)

Exclusions

This Plan does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services
- comfort items
- private duty nursing
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- care or services received after the member’s coverage terminates

HOSPITAL/OTHER FACILITY SERVICES

Blood Services

This Plan covers the processing, transporting, handling, and administration of blood and blood components. This Plan covers directed donor or autologous blood storage fees only when the blood is used during a scheduled surgical procedure. This Plan does **not** cover blood replaced through donor credit.

Inpatient Services

Preauthorization Required

If hospitalization is recommended by a Nonpreferred Provider or you are outside New Mexico, **you are responsible** for obtaining preauthorization. If you do not follow the inpatient preauthorization procedures, benefits for covered facility services will be **denied** as explained in *Section 4: Preauthorizations*.

Covered Services

For acute inpatient medical or surgical care received during a covered hospital admission, this Plan covers room and board and other Medically Necessary services provided by the facility.

Medical Detoxification

This Plan also covers Medically Necessary services related to medical detoxification from the effects of alcohol or drug abuse. Detoxification is the treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse, which usually takes about three days in an acute care facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition. Preauthorization is required for all inpatient hospitalizations. See “Psychotherapy (Mental Health and Chemical Dependency)” for information about benefits for chemical dependency rehabilitation. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Exclusions

This Plan does **not** cover:

- transplants or related services when transplant received at a facility that does not contract directly with a BCBSNM Participating Provider or through a BCBS transplant network. (See “Transplant Services” for more information.)
- admissions related to noncovered services or procedures
- custodial care facility admissions

Outpatient or Observation Services

Coverage for outpatient or observation services and related physician or other professional provider services for the treatment of illness or accidental injury depends on the type of service received (for example, see “Lab, X-Ray, Other Diagnostic Services” or “Emergency and Urgent Care”).

INFUSION THERAPY

Some outpatient infusion services for routine maintenance drugs have been identified as capable of being administered, outside of an outpatient Hospital setting. Member out-of-pocket expenses may be lower when services are provided by a professional Provider in an infusion suite, a home or an office, instead of a Hospital. Non-maintenance outpatient infusion therapy services will be covered the same as any other illness. If covered, the SBC describes payment for infusion therapy services.

For more information, you may contact a Customer Service Advocate at the toll-free number on your Identification Card.

LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see “Surgery and Related Services.”

This Plan covers diagnostic services, including but not limited to, preadmission testing, that are related to an illness or accidental injury. Covered services include:

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see “Maternity/Reproductive Services and Newborn Care.”)
- infertility-related testing (See “Maternity/Reproductive Services and Newborn Care.”)
- PET (Positron Emission Tomography) scans, cardiac CT scans with **preauthorization** from BCBSNM
- MRIs

- psychological or neuropsychological testing with **preauthorization** from BCBSNM
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

Note: All services, including those for which preauthorization is required, must meet the standards of medical necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this Plan. **Some services requiring preauthorization will not be approved for payment.**

MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

Like benefits for other conditions, member cost-sharing amounts for pregnancy, family planning, infertility, and newborn care are based on the place of service and type of service received.

Family Planning and Infertility-Related Services

For Preventive oral contraceptive coverage and contraceptive devices purchased from a pharmacy, see your Drug Plan Rider.

Family Planning

Covered family planning services include:

- health education
- the following categories of FDA-approved contraceptive drugs, devices, and services, subject to change as FDA guidelines are modified: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended-cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices (IUDs), injectables, transdermal contraceptives, and vaginal contraceptive devices
- pregnancy testing and counseling
- vasectomies

For these following covered family planning services, no coinsurance, deductible, copayment, or benefit maximums will apply when received from a provider in the preferred or Participating Provider network. When these services are received from an out-of-network provider, if your plan has out-of-network benefits for non-emergency services, the usual out-of-network deductible, coinsurance, and out-of-pocket will apply.

- over-the-counter female contraceptive devices with a written prescription by a health care provider
- FDA-approved contraceptive drugs and devices from the following categories of FDA-approved contraceptive drugs, devices, and services, subject to change as FDA guidelines are modified: progestin-only contraceptives, combination contraceptives, Emergency contraceptives, extended-cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices (IUDs), injectables, transdermal contraceptives, and vaginal contraceptive devices. Covered FDA approved contraceptive drugs and devices are listed on the contraceptive drugs and devices list posted on the BCBSNM website (http://bcbsnm.com/affordable_care_act/provisions.html), or (<http://www.bcbsnm.com/pdf/rx/contraceptive-list-nm.pdf>) or available by contacting your Customer Service Advocate at the toll-free number on your ID card
- outpatient contraceptive services such as consultations, examinations, procedures (including follow-up care for trouble you may have from using a birth control method that a family planning provider gave you) and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy
- birth control pills (covered under the drug plan provision)
- pregnancy testing and counseling
- injection of Depo-Provera for birth control purposes
- diaphragm, including fitting
- IUDs or cervical caps, including fitting, insertion, and removal
- surgical sterilization procedures such as vasectomies and tubal ligations

- female surgical sterilization procedures (other than hysterectomy), including tubal ligations

When obtaining the items noted above, you may be required to pay the full cost and then submit a claim form with itemized receipts to BCBSNM for reimbursement. Please refer to the *Section 8: Claims Payments and Appeals* of this Benefit Booklet for information regarding submitting claims.

Infertility-Related Services

This Plan covers the following infertility-related treatments. (**Note:** the following procedures only *secondarily* treat infertility):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas deferens when the obstruction is **not** the result of a surgical sterilization
- replacement of deficient, naturally occurring hormones **if** there is documented evidence of a deficiency of the hormone being replaced

The above services are the **only** infertility-related treatments that will be considered for benefit payment.

Diagnostic *testing* is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing is covered. For example, this Plan will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.

Exclusions

In addition to services not listed as covered above, this Plan does **not** cover:

- male contraceptive devices, including over-the-counter contraceptive products such as condoms
- sterilization reversal for males or females
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm
- artificial conception or insemination; fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro (test tube) fertilization, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception

Pregnancy-Related/Maternity Services

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery.

A covered daughter also has coverage for pregnancy-related services. However, if the parent of the newborn is a covered child of the subscriber (i.e., the newborn is the subscriber's grandchild), benefits are **not** available for the newborn except for the first 48 hours of routine newborn care (or 96 hours in the case of a C-section).

Covered Services

Covered pregnancy-related services include:

- hospital or other facility charges for semiprivate room and board and ancillary services, including the use of labor, delivery, and recovery rooms (This Plan covers all Medically Necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. **Note:** Newborns who are not eligible for coverage under this Plan will not be covered beyond the 48 or 96 hours required under federal law.)

- routine or complicated delivery, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife or licensed midwife (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy. The office visit during which a pregnancy is confirmed is subject to the member cost-sharing provisions that apply to any other office visit.) **Note:** Home births are not covered unless the provider has a Preferred Provider contract with his/her local BCBS Plan and is credentialed to provide the service.
- pregnancy-related diagnostic tests, including genetic testing or counseling if preauthorized by BCBSNM (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.) See *Section 4: Preauthorizations* for more information about Preauthorization requirements.
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly born infants (See “Ambulance Services” for details.)
- services of a physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- spontaneous, or therapeutic termination of pregnancy prior to full term

Special Beginnings

This is a maternity program for BCBSNM members that is available whenever you need it. It can help you better understand and manage your pregnancy. To take full advantage of the program, you should enroll within three months of becoming pregnant. When you enroll, you will receive a questionnaire to find out if there may be any problems with your pregnancy to watch out for, information on nutrition, newborn care, and other topics helpful to new parents. You will also receive personal and private phone calls from an experienced nurse – all the way from pregnancy to six weeks after your child is born. To learn more, or to enroll, call toll-free at:

1-888-421-7781

Newborn Care

If you have Family coverage on the date a new Eligible Child is born, the initial newborn care for the child is covered. If you do not have coverage for your newborn on the date of birth, you must add coverage within 31 days of birth in order for any newborn charges, routine or otherwise, to be covered beyond the first 48 hours of birth (or 96 hours in the case of a C- section).

Newborn Eligibility

If you do not elect to add coverage for your newborn within 31 days, and wish to add the child to coverage later, the child is considered a late applicant unless eligible for a special enrollment. **Note:** If the parent of the newborn is a covered child of the subscriber (i.e., the newborn is the subscriber’s grandchild), services for the newborn are **not** covered except for the first 48 hours of routine newborn care (or 96 hours in the case of a C-section).

Routine Newborn Care

If both the mother’s charges and the baby’s charges are eligible for coverage under this Plan, no additional deductible for the newborn is required for the facility’s initial routine nursery care if the covered newborn is discharged on the same day as the mother.

Covered Services

Covered services for initial routine newborn care include:

- routine hospital nursery services, including alpha-fetoprotein IV screening

- routine medical care in the hospital after delivery
- pediatrician standby care at a C-section procedure
- services related to circumcision of a male newborn

For children who are covered from their date of birth, benefits include coverage of injury or sickness, including covered services related to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as required by New Mexico state law.

Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in *Section 2: Enrollment and Termination Information* is also covered if he/she stays in the hospital longer than the mother. The baby's services will be subject to a separate deductible, coinsurance, hospital copayment and out-of-pocket limit.

If you are in a nonpreferred facility, you must ensure that BCBSNM is called **before** the mother is discharged from the hospital. If you do not, benefits for the newborn's covered facility services will be paid at the Nonpreferred Provider benefit level. The baby's services will be subject to a separate deductible, coinsurance and out-of-pocket limit.

PHYSICIAN VISITS/MEDICAL CARE

This section describes benefits for therapeutic injections, allergy care and testing, and other nonsurgical, nonroutine medical visits to a health care provider for evaluating your condition and planning a course of treatment. See specific topics referenced in this section for more information regarding a particular type of service (e.g., "Preventive Services," "Transplant Services," etc.).

This Plan covers Medically Necessary care provided by a physician or other professional provider for an illness or accidental injury. **Your choice of provider can make a difference in the amount you pay.** (See *Section 3: How Your Plan Works*.)

Office Visits and Consultations

Benefits for services received in a physician's office are based on the type of service received while in the office. Services covered under this provision include allergy care, therapeutic injections, office visits, consultations (including second or third surgical opinions) and examinations, and other nonroutine office medical procedures — when not related to hospice care or payable as part of a surgical procedure. (See "Hospice Care" or "Surgery and Related Services" if the medical visits are related to either of these services.)

Allergy Care

This Plan covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), allergy serum, and appropriate FDA-approved allergy injections administered in a provider's office or in a facility.

Breastfeeding Support and Services

This Plan covers counseling and support services rendered by a lactation consultant such as a certified nurse practitioner, certified nurse midwife or midwife, not subject to coinsurance, deductible, copayment, or benefit maximums when received from a provider in the preferred or Participating Provider (if your plan has out-of-network benefits for non-emergency services, out-of-network services are subject to the usual out-of-network deductible, coinsurance, and out-of-pocket).

Genetic Inborn Errors of Metabolism

This Plan covers Medically Necessary expenses related to the diagnosis, monitoring and control of genetic inborn errors of metabolism as defined in *Section 10: Definitions*. Covered services include medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs (see your *Drug Plan Rider*), corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and **preauthorized** special medical foods (as defined and described in your *Drug Plan Rider*). In order to be covered, services cannot be excluded under any other provision of this benefit booklet and are paid according to the provisions of the Plan that apply to that particular type of service (e.g., special medical foods are covered under your Drug Plan Rider,

medical assessments under “Physician Visits/Medical Care” and corrective lenses under “Supplies, Equipment and Prosthetics”).

To be covered, the member must be receiving medical treatment provided by licensed health care professionals, including physicians, dietitians and nutritionists, who have specific training in managing patients diagnosed with genetic inborn errors of metabolism.

Injections and Injectable Drugs

This Plan covers most FDA-approved therapeutic injections administered in a provider’s office. However, this Plan covers some injectable drugs only when **preauthorization** is received from BCBSNM. Your BCBSNM-contracted provider has a list of those injectable drugs that require preauthorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. (When you request preauthorization, you may be directed to purchase the self-injectable medication through your drug plan.)

BCBSNM reserves the right to exclude any injectable drug currently being used by a member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM Customer Service Advocate if you have any questions about this policy.

Mental Health Evaluation Services

This Plan covers medication checks and intake evaluations for mental disorders, alcohol, and drug abuse. See “Psychotherapy (Mental Health and Chemical Dependency)” for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

With the exception of dental-related services, this Plan covers the following services when received on a covered inpatient hospital day:

- visits for a condition requiring **only** medical care, unless related to hospice care
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a provider who is not the surgeon and who provides medical care **not** related to the surgery (For the surgeon’s services, see “Surgery and Related Services” or “Transplant Services.”)
- medical care requiring **two or more** physicians at the same time because of multiple illnesses
- initial routine newborn care for a newborn added to coverage within the time limits specified in *Section 2: Enrollment and Termination Information* (See “Maternity/Reproductive Services and Newborn Care” for details and for extended stay benefits.)

PREVENTIVE SERVICES

The services listed under this provision are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient’s age group, such as providing a pediatric immunization to an adult). You and your physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your health care plan. Coverage for a recommended preventive service that is otherwise considered medically necessary for an individual will be provided regardless of an individual’s sex assigned at birth, gender identity or gender that BCBSNM has recorded.

This Plan covers the following preventive services not subject to coinsurance, deductible, copayment, or benefit maximums (to be implemented in the quantities and within the time period allowed under applicable law) when received from an in-network provider. Out-of-network services are subject to the usual out-of-network deductible, coinsurance, and out-of-pocket limit.

- a. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);

- b. immunizations for routine use that have in effect a recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- c. evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents;
- d. with respect to women, to the extent not described in item “a” above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

For purposes of item “a” above, the current recommendations of the USPSTF regarding breast cancer screening mammography and prevention issued in or around November 2009 are not considered to be current.

The preventive services described in items “a” through “d” above may change as USPSTF, CDC, and HRSA guidelines are modified. For more information, you may visit the BCBSNM website at www.bcbsnm.com or contact Customer Service at the toll-free number on your BCBSNM health plan identification card.

Covered preventive services **not** described in items “a” through “d” above may be subject to deductible, coinsurance, copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the “Preventive Services” benefit. Examples of covered preventive services include, but are not limited to:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- human papillomavirus vaccine (HPV) for members ages 9 - 26 years old
- periodic blood hemoglobin, blood pressure and blood glucose level tests
- periodic colorectal screening tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood
- periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy
- well-child care, including well-baby and well-child screening for diagnosing the presence of autism spectrum disorder
- periodic glaucoma eye tests
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for members (through age 17) when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use cessation counseling
- contraceptive drugs and devices

The services listed above are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient’s age group, such as providing a pediatric immunization to an adult). You and your physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefit and limitation of your health care plan.

Exclusions

This Plan does **not** cover:

- routine or preventive services of a Nonpreferred Provider

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the member's work
- routine hearing examinations, hearing aids, or any related service or supply for members age 21 and older (for hearing aid and related services for children under age 21, see "Supplies, Equipment, and Prosthetics" later in this section); routine eye exams or eye refractions; hearing or visual screening for members over age 17

PSYCHOTHERAPY (MENTAL HEALTH AND CHEMICAL DEPENDENCY)

Note: You do not receive a separate mental health/chemical dependency ID card; use your BCBSNM ID card to receive all medical/surgical and mental health/chemical dependency services covered under this Plan.

Medical Necessity

In order to be covered, treatment must be Medically Necessary and not Experimental, Investigational or Unproven. Therapy must meet the following definition and conditions:

Medically Necessary/Medical Necessity is defined as Health Care Services that BCBSNM determines a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Hospital, Physician, or other Provider, and not more costly, as determined by BCBSNM or its agents, than an alternative clinical service, therapy, or procedure or sequence of services, therapies, and procedures that based on evidence-based clinical data are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For Psychotherapy (Mental Health and Chemical Dependency) medically necessity determinations, the applicable generally accepted principles and practices of good medical care and practices guidelines developed by the American Psychiatric Association are contained in the latest version of the *Diagnostic and Statistical Manual* published by the American Psychiatric Association.

Preauthorization Requirements

Preauthorizations are a requirement that you or your Provider must obtain authorization from BCBSNM *before* you are admitted as an inpatient or receive certain types of services.

In order to receive benefits:

- services must be covered and medically necessary;
- services must not be excluded; and
- the procedures described in this section must be followed regardless of where services are rendered or by whom.

Preauthorization determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. **Preauthorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive benefits.** Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this Plan, and services that are not medically necessary will be denied.

Services Requiring Preauthorization

All inpatient mental health and Chemical Dependency services (e.g., partial hospitalization, residential treatment centers) must be Preauthorized by the Behavioral Health Unit at the phone number listed on the back of your ID card. Preauthorization is also required for the following outpatient services for treatment of mental illness and/or Chemical Dependency:

- outpatient psychological testing
- neuropsychological testing
- Intensive Outpatient Program (IOP) treatment
- electroconvulsive therapy (ECT)
- repetitive transcranial magnetic stimulation
- Applied Behavior Analysis (ABA) therapies

You or your Physician should call the Behavioral Health Unit **before** you schedule treatment. If you do not call before receiving non-emergency services, **benefits for Covered Services may be reduced or denied** as explained in the *Preauthorizations* section, earlier. In such cases, you may be responsible for all charges, so please ensure that you or your Provider have received Preauthorization for any services you plan to receive. The BHU Call Center is open 24/7 to assist Members and Providers with Emergency Admission inquiries and to respond to crisis calls.

Benefit Limits – Benefits for inpatient and outpatient psychotherapy (whether required due to mental illness, chemical dependency, or any other covered condition) and related adjunctive services are subject to your regular deductible and out-of-pocket limits, to the lifetime maximum dollar benefit, and the same copayments or coinsurance amounts that are applied to similar services for medical conditions as specified on the Summary of Benefits. For services that do not have equivalents in the medical treatment category, copayments are as follows:

- Intensive Outpatient Programs (IOP) – member share for each visit is same as for office visits
- Partial hospitalization – member share is same as for inpatient hospitalization

If you are admitted for a medical condition and later transferred to another unit in the same or different facility for drug abuse rehabilitation (or vice versa), **both admissions must receive preauthorization.**

Preauthorization is **not** required for group, individual, or family therapy office visits to a Physician or other Professional Provider licensed to perform Covered Services under this Plan.

Covered Services/Providers

Covered services include solution-focused evaluative and therapeutic mental health services (including individual and group psychotherapy) received in a psychiatric hospital, an IOP (intensive outpatient program), or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed psychologists, and other providers as defined in *Section 10: Definitions*. Mental disorders that respond to and require long-term treatment with medications and/or therapeutic treatment including schizophrenia, bi-polar disorder, and chronic depression are also covered.

Residential Treatment Centers

Residential treatment centers are covered by this Plan. A residential treatment center is a facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients in residential treatment centers are medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with mental illness and/or chemical dependency disorders.

BCBSNM requires that any mental health residential treatment center must be appropriately licensed in the state where it is located or accredited by a national organization that is recognized by BCBSNM as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Exclusions

This Plan does **not** cover:

- care that has not been preauthorized
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services billed by a school, halfway house or group home, or their staff members; foster care; or behavior modification services
- long-term therapy or therapy for the treatment of chronic mental disorders or incurable conditions for which treatment produces minimal or temporary change of relief – except that medication management for chronic conditions is covered (Chronic conditions are conditions such as, but not limited to, autism, Down’s Syndrome and developmental delays.) See “Early Developmental Delay and Disability” in *Section 8: Claims Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.
- maintenance therapy or care provided after you have reached your rehabilitative potential (See the “Long-Term or Maintenance Therapy” exclusion in the *General Limitations and Exclusions* section.)
- biofeedback, hypnotherapy, or behavior modification services
- religious or pastoral counseling
- custodial care (See the “Custodial Care” exclusion in *Section 6: General Limitations and Exclusions*.)
- hospitalization or admission to a Skilled Nursing Facility (SNF), nursing home, or other Facility for the primary purpose of providing custodial care service, convalescent care, rest cures, or domiciliary care to the patient
- services or supplies received during an inpatient stay when the stay is solely related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions)
- any care that is patient-elected and is not considered Medically Necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental disorders or other disturbances (See “Early Developmental Delay and Disability” in *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- non-national standard therapies, including those that are experimental as determined by the mental health professional practice
- the cost of any damages to a treatment facility
- charges associated with any episode of alcoholism or drug abuse for which you did not complete the prescribed continuum of care

REHABILITATION AND OTHER THERAPY

When billed by a facility during a covered admission, therapy is covered in the same manner as the other ancillary services (see “Hospital/Other Facility Services”).

Acupuncture and Spinal Manipulation

This Plan covers acupuncture and osteopathic or spinal manipulation services (application of manual pressure or force to the spine) when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of a medical condition. Benefits for acupuncture and for spinal manipulation are limited as specified in the *Summary of Benefits*. **Note:** If your provider charges for other services in addition to acupuncture or manipulation, the other services will be covered according to the type of service being claimed. For example,

physical therapy services from a provider on the same day as an acupuncture or manipulation service will apply toward the “Short-Term Rehabilitation” benefit.

Exclusions – This Plan does not cover:

- acupuncture or spinal manipulations received from Nonpreferred Providers
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing
- any therapeutic exercise equipment prescribed for home use

Cardiac and Pulmonary Rehabilitation

This Plan covers outpatient cardiac rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services. **Services must be received from a Preferred Provider in order to be covered.**

Chemotherapy and Radiation Therapy

This Plan covers the treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy.

Cancer Clinical Trials

If you are a participant in an approved cancer clinical trial, you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of re-occurrence, early detection, or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified cancer clinical trial and must accept BCBSNM’s covered charges as payment in full (this includes the health care Plan’s payment plus your share of the covered charge).

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor, or supplier of the drug. (Member cost-sharing provisions described under your separately issued *Drug Plan Rider* will apply to these benefits.) If benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

Benefits for Routine Patient Care Costs for Participation in Certain Clinical Trials

Benefits for eligible expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is recognized under state and/or federal law.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial. If benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

Dialysis

This Plan covers the following services when received from a dialysis provider:

- renal dialysis (hemodialysis)
- continual ambulatory peritoneal dialysis (CAPD)
- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home dialysis

Short-Term Rehabilitation: Occupational, Physical, Speech Therapy (Inpatient and Outpatient, Including Skilled Nursing Facility)

Preauthorization Required

To be covered, all **inpatient**, short-term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **preauthorization** from BCBSNM and be received from a **preferred provide**. See *Section 4: Preauthorizations* for more information about preauthorization requirements. Services are not covered when received from Nonpreferred Providers.

Covered Services

This Plan covers the following short-term rehabilitation services when rendered by a Preferred Provider for the Medically Necessary treatment of accidental injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine)
- joint and spinal manipulation services when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of accidental injury or medical condition
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and skilled nursing facility services when **preauthorized** by BCBSNM

Conditions of Coverage

To be eligible for benefits, therapies must meet the following conditions:

- Services must be received from Preferred Providers
- There is a documented condition or delay in recovery that can be expected to measurably improve with short-term therapy within two months of beginning active therapy.
- Improvement would not normally be expected to occur without interventions.

Benefit Limits

Benefits are limited, if applicable, as specified in the *Summary of Benefits*. **Note:** Long-term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This Plan covers short-term rehabilitation only.

Exclusions

This Plan does **not** cover:

- services of a Nonpreferred Provider
- maintenance therapy or care provided after you have reached your rehabilitative potential except as required under New Mexico State law (Even if you have not reached your rehabilitative potential, this Plan does not cover services that exceed maximum benefit limits, if any.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in this *Covered Services* section under “Autism Spectrum Disorders” (See “Early Developmental Delay and Disability” in *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- private room expenses
- services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider

- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- long-term therapies (therapies are long-term if measurable improvement is not possible within two months of beginning active therapy, except as required under New Mexico state law. This plan does not cover long-time therapy even if you have not yet used or exhausted maximum benefits.)
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing

SMOKING/TOBACCO USE CESSATION

This Plan covers smoking and tobacco cessation treatment, limited to the following diagnostic and counseling services received from **Preferred Providers** and drug therapy that has been **preauthorized** by **BCBSNM** (subject to member cost-sharing provisions applicable to the type of service received, such as prescription drugs, counseling, etc.):

- Diagnostic services to identify tobacco use, use-related conditions, and dependence
- a choice of cessation counseling of up to 90 minutes total provider contact time or two multi-session group programs per benefit period (Covered counseling is restricted to programs that meet minimum requirements established by the NM Public Regulation Commission.) See *Section 10: Definitions for minimum cessation counseling requirements*.

Starting any course of prescription drug therapy or cessation counseling constitutes one entire course of drug therapy or cessation counseling – even if you discontinue or fail to complete the course. For example, if you purchase a one-month supply of a prescription drug for smoking cessation and do not continue the drug beyond one month, you will have used up one entire 90-day course of treatment with the 30-day supply.

To locate a provider that is approved to provide cessation counseling sessions, you may call BCBSNM Customer Service or ask your personal physician about obtaining a prescription for smoking cessation drugs.

Exclusions

This Plan does **not** cover the following services:

- cessation counseling or treatment received from Nonpreferred Providers or drug therapy that has not received preauthorization (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)
- acupuncture, biofeedback, or hypnotherapy for smoking/tobacco use cessation
- over-the-counter tobacco cessation products, including but not limited to items such as nicotine patches or nicotine gum (See for copayments and other limitations that apply to prescription drugs.)

SUPPLIES, EQUIPMENT AND PROSTHETICS

To be covered, items must be medically necessary and ordered by a health care provider. If you have a question about durable medical equipment, medical supplies, prosthetics or appliances not listed, please call the BCBSNM Health Services Department.

Diabetic Supplies and Equipment

This Plan covers the following supplies and equipment for diabetic members and individuals with elevated glucose levels due to pregnancy (supplies are not to exceed a **30-day supply** purchased during any 30-day period):

- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps and insulin pump supplies
- blood glucose monitors, including those for the legally blind

- medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications

Reminder: For additional diabetic supply coverage, (e.g., insulin needle and syringes, autolet, glucose meters, test strips for glucose monitors, glucagon emergency kits), see your separately issued *Drug Plan Rider*.

Note: The Plan will also cover items not specifically listed as covered when new and improved equipment, appliances, and prescription drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration. This Plan will: 1) maintain an adequate formulary to provide these resources to individuals with diabetes; and 2) guarantee reimbursement or coverage for the equipment, appliances, prescription drugs, insulin, or medical supplies described in this benefit booklet within the limits of this Plan.

Breast Pumps

This plan covers the rental (but not to exceed the total cost) or purchase of manual, electric, or hospital grade breast pumps and supplies with a written prescription from a health care provider. The rental or purchase cost of manual, electric, or hospital grade breast pumps and supplies are not subject to coinsurance, deductible, copayment, or benefit maximums when received from an in-network provider (if your plan has out-of-network benefits for non-emergency services, out-of-network services are subject to the usual out-of-network deductible, coinsurance, and out-of-pocket). Electric breast pumps are limited to 1 per Calendar Year.

Durable Medical Equipment and Appliances

This Plan covers the following items:

- orthopedic appliances
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other Medically Necessary durable medical equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when needed to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- the rental of (or a the option of BCBSNM, the purchase of) durable medical equipment (including repairs to such purchased items), when prescribed by a covered health care provider and required for therapeutic use

This Plan covers the rental (or at the option of BCBSNM, the purchase of) durable medical equipment (including repairs to or replacement of such purchased items), when prescribed by a covered health care provider and required for therapeutic use.

Medical Supplies

This Plan covers the following medical supplies, not to exceed a **30-day supply** purchased during any 30-day period, unless otherwise indicated:

- colostomy bags, catheters
- gastrostomy tubes

- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a physician or other provider during a covered office visit
- slings
- support hose prescribed by a physician for treatment of varicose veins (six pair per Calendar Year)

Orthotics and Prosthetic Devices

This Plan covers the following items when Medically Necessary and ordered by a provider:

- surgically implanted prosthetics or devices, including penile implants required as a result of illness or accidental injury
- externally attached prostheses to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, repairs and replacement
- replacement of prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy and mastectomy bras, which are limited to **four bras** per Calendar Year
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints and prescribed by a physician or podiatrist.)
- orthotics (e.g., collars, braces, molds) prescribed by an eligible provider to protect, restore, or improve impaired body function

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the most cost-effective item.

Exclusions

This Plan does **not** cover, regardless of therapeutic value, items such as, but not limited to:

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair or rental costs that exceeds the purchase price of a new unit
- dental appliances (See "Dental-Related Services and Oral Surgery" for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members should refer to "Diabetic Supplies and Equipment" earlier in this section for information about covered podiatric equipment and orthopedic shoes.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- stethoscopes or blood pressure monitors

- voice synthesizers or other communication devices
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies for persons 21 or older or, if under age 21, in excess of the maximum benefit described in this section (For surgically implanted devices for the profoundly hearing impaired, see “Surgery and Related Services” below.)
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under your separately issued *Drug Plan Rider*.)
- items that can be purchased over-the-counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages
- male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a health care provider. (See “Maternity/Reproductive Services and Newborn Care: Family Planning” for devices requiring a prescription.)
- items not listed as covered
- costs for items received from a Nonpreferred Provider

SURGERY AND RELATED SERVICES

To be covered, preauthorization from BCBSNM must be received for all inpatient surgical procedures. See “Preauthorizations” in Section 4 for details.

Surgeon’s Services

Covered services include surgeon’s charges for a covered surgical procedure.

Cochlear Implants

This Plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device.

Mastectomy Services

This Plan covers Medically Necessary hospitalization related to a covered mastectomy (including at least 48 hours of inpatient care following a mastectomy and 24 hours following a lymph node dissection).

This Plan also covers reconstructive breast surgery following a covered mastectomy. Coverage is limited to:

- surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures
- the initial surgery of the other breast to produce a symmetrical appearance
- prostheses and treatment of physical complications following the mastectomy, including treatment of lymphedema

This Plan does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery.

Reconstructive Surgery

Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect. This Plan covers reconstructive surgery when required to correct a **functional** disorder caused by:

- an accidental injury
- a disease process or its treatment (For breast surgery following a mastectomy, see “Mastectomy Services,” above.)
- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

Cosmetic procedures and procedures that are **not Medically Necessary**, including all services related to such procedures, may be **denied**.

Exclusions

This Plan does **not** cover:

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under “Mastectomy Services”)
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of Medically Necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant, or previous cosmetic surgery)
- obesity treatment, including the surgical treatment of morbid obesity
- the insertion of artificial organs, or services related to transplants not specifically listed as covered under “Transplant Services”
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists

Anesthesia Services

This Plan covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), or other practitioner licensed to provide anesthesia. (See “Rehabilitation and Other Therapy” for information about acupuncture benefits.)

Exclusions

This Plan does **not** cover local anesthesia except for preventive colonoscopies. (Coverage for surgical procedures includes an allowance for local anesthesia because it is considered a routine part of the surgical procedure.)

Assistant Surgeon Services

Covered services include services of a professional provider who actively assists the operating surgeon in the performance of a covered surgical procedure when the procedure requires an assistant.

Exclusions

This Plan does **not** cover:

- services of an assistant only because the hospital or other facility requires such services
- services performed by a resident, intern, or other salaried employee or person paid by the hospital
- services of more than one assistant surgeon unless the procedure is identified by BCBSNM as requiring the services of more than one assistant surgeon

TRANSPLANT SERVICES

Preauthorization, requested in writing, must be obtained from BCBSNM by the provider **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if preauthorization is not obtained from BCBSNM. If approved, a BCBSNM case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation.

If you are approved as a transplant recipient candidate, you must ensure that **preauthorization** for the actual transplant is also received. None of the benefits described here are available unless you have this preauthorization. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Facility Must Be in Transplant Network

Benefits for covered services will be approved only when the transplant is performed at a facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS transplant network, for the transplant being provided. Your BCBSNM case manager will assist your provider with information on the exclusive network of contracted facilities and required approvals. Call BCBSNM Health Services for information on these BCBSNM transplant programs.

Effect of Medicare Eligibility on Coverage

If you are now eligible for (or are *anticipating* receiving eligibility for) Medicare benefits, **you** are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.

Organ Procurement or Donor Expenses

If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver is also covered. If there is a living donor that requires surgery to make an organ available for a covered transplant, coverage is available for expenses incurred by the donor for surgery, organ storage expenses, and inpatient follow-up care only.

This Plan does **not** cover donor expenses after the donor has been discharged from the transplant facility. Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Bone Marrow, Cornea or Kidney

This Plan covers the following transplant procedures if **preauthorization** is received from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.):

- bone marrow transplant for a member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome, and other conditions determined by BCBSNM to be Medically Necessary and not experimental, investigational, or unproven
- cornea transplant
- kidney transplant

Cost-Sharing Provisions

Covered services related to the above transplants are subject to the usual cost-sharing features and benefit limits of this Plan (e.g., deductible, coinsurance, copayments and out-of-pocket limits; and annual home health care maximums, if applicable).

Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney

This Plan covers transplant-related services for a **heart, heart-lung, liver, lung or pancreas-kidney** transplant. Services must be **preauthorized** in order to be covered. All other limitations, requirements, and exclusions of this “Transplant Services” provision apply to these transplant-related services. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

In addition to the general provisions of this “Transplant Services” section, the following benefits, limitations, and exclusions apply to the above-listed transplants for **one year** following the date of the actual transplant or retransplant. After one year, usual benefits apply and the services must be covered under other provisions of the Plan in order to be considered for benefit payment.

Recipient Travel and Per Diem Expenses

If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, travel to the city where the transplant will be performed is covered. A standard

per diem benefit (**\$50**) will be allocated for lodging expenses for the recipient and one additional adult traveling with the transplant recipient. If the transplant recipient is an eligible child under the age of 18, benefits for travel and per diem expenses for **two adults** to accompany the child are available.

Travel expenses and standard per diem allowances are limited to a total combined lifetime maximum benefit of **\$10,000** per transplant. Your case manager may approve travel and per diem lodging allowances based upon the total number of days of temporary relocation, up to the **\$10,000** benefit maximum.

Travel expenses are **not** covered and per diem allowances are **not** paid if you *choose* to travel to receive a transplant for which travel is not considered Medically Necessary by the case manager or if the travel occurs **more than five days** before or **more than one year** following the transplant or retransplant date.

Transplant Exclusions

This Plan does **not** cover:

- transplant-related services for a transplant that did not receive **preauthorization** from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)
- any transplant or organ-combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM medical policy)
- nonhuman organ transplants
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home unless specifically covered under this Plan
- donor expenses after the donor has been discharged from the transplant facility
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- travel or per diem expenses:
 - incurred **more than five days before** or **more than one year following** the date of transplantation
 - if the recipient's case manager indicates that travel is not Medically Necessary
 - related to a bone marrow or kidney transplant (unless services are not reasonably available within your community without travel)
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does not ordinarily do so)

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** services listed in this benefit booklet and your *Drug Plan Rider*.

This Plan does not cover any service or supply not specifically listed as a covered service in this benefit booklet. If a service is not covered, then all services performed in conjunction with it are not covered.

This Plan will not cover any of the following services, supplies, situations, or related expenses:

— Before Effective Date of Coverage

This Plan does not cover any service received, item purchased, prescription filled, or health care expense incurred before your effective date of coverage. If you are an inpatient when coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

— Biofeedback

This Plan does not cover services related to biofeedback.

— Blood Services

This Plan does not cover directed donor or autologous blood storage fees when the blood is used during a nonscheduled surgical procedure. **This Plan does not cover** blood replaced through donor credit.

— Complications of Noncovered Services

This Plan does not cover any services, treatments, or procedures required as the result of complications of a noncovered service, treatment, or procedure (e.g., due to a cosmetic surgery, transplant, or experimental procedure).

— Convalescent Care or Rest Cures

This Plan does not cover convalescent care or rest cures.

— Cosmetic Services

Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. **This Plan does not cover** cosmetic surgery, services, or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. **This Plan does not cover** services related to or required as a result of a cosmetic service, procedure, surgery, or subsequent procedures to correct unsatisfactory cosmetic results attained during an initial surgery.

Examples of cosmetic procedures are: dermabrasion; revision of surgically induced scars; breast augmentation; rhinoplasty; surgical alteration of the eye; correction of prognathism or micrognathism; excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, legs, or buttock; services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body including, but not limited to, breast, face, lips, jaw, chin, nose, ears, or genitals; **or any procedures that BCBSNM determines are not required to materially improve the physiological function of an organ or body part unless Medically Necessary.**

Exception: Breast/nipple surgery performed as reconstructive procedures following a covered mastectomy may be covered. However, **Preauthorization**, requested in writing, must be obtained from BCBSNM for such services. Also, reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect.

— Custodial Care

This Plan does not cover Custodial Care. Custodial Care is any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care includes those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be

safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel assisting with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.), and/or assisting with activities of daily living (e.g., bathing, eating, dressing, etc.).

— **Dental-Related Services and Oral Surgery**

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see “Dental-Related Services and Oral Surgery” in *Section 5: Covered Services* for additional exclusions.

— **Domiciliary Care**

This Plan does not cover domiciliary care or care provided in a residential institution, treatment center, halfway house, or school because your own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

— **Duplicate (Double) Coverage**

This Plan does not cover amounts already paid by other valid coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. See *Section 7: Coordination of Benefits and Reimbursement* for more information. Also, if your prior coverage has an extension of benefits provision, **this Plan will not cover** charges incurred after your effective date of coverage under this Plan that are covered under the prior plan’s extension of benefits provision.

— **Duplicate Testing**

This Plan does not cover duplicative diagnostic testing or overreads of laboratory, pathology, or radiology tests.

— **Experimental, Investigational, or Unproven Services**

This Plan does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical practice* (as defined) or those considered experimental, investigational, or unproven, unless for acupuncture rendered by a licensed doctor of oriental medicine or unless specifically listed as covered under “Autism Spectrum Disorders” or under “Cancer Clinical Trials” in *Section 5: Covered Services*. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. *Experimental or investigational* does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

The service must be Medically Necessary and not excluded by any other contract exclusion.

Standard medical practice means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or other facility provider in which they were performed; and
- the physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

— Food or Lodging Expenses

This Plan does not cover food or lodging expenses, except for those lodging expenses that are eligible for a per diem allowance under “Transplant Services” in *Section 5: Covered Services*, and not excluded by any other provision in this section.

— Genetic Testing or Counseling

This Plan does not cover tests such as amniocentesis or ultrasound to determine the gender of an unborn child. See “Maternity/Reproductive Services and Newborn Care” in *Section 5: Covered Services* for details.

— Hair Loss Treatments

This Plan does not cover wigs, artificial hairpieces, hair transplants or implants, or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

— Hearing Examinations, Procedures and Aids

This Plan does not cover audiometric (hearing) tests **unless** 1) required for the diagnosis and/or treatment of an accidental injury or an illness, or 2) covered as a preventive *screening* service, or 3) covered as part of the hearing aid benefit for members under age 21 and described under “Hearing Aids/Related Services for Children under Age 21” in *Section 5: Covered Services*. (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This Plan does not cover** hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for **members age 21 and older**. For **members** under **age 21**, see “Hearing Aids/Related Services for Children Under Age 21” in *Section 5*. (For surgically implanted devices, see “Surgery and Related Services” in *Section 5: Covered Services*.)

— Home Health, Home I.V. and Hospice Services

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see “Home Health Care/Home I.V. Services” or “Hospice Care” in *Section 5: Covered Services* for additional exclusions.

— Hypnotherapy

This Plan does not cover hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

— Infertility Services/Artificial Conception

This Plan does not cover services related to, but not limited to, procedures such as: artificial conception or insemination, fertilization and/or growth of a fetus outside the mother’s body in an artificial environment, such as in-vivo or in-vitro (“test tube”) fertilization, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), embryo transfer, drugs for induced ovulation, or other artificial methods of conception. **This Plan does not cover** the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees.

This Plan does not cover infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization.

This Plan does not cover reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see “Maternity/Reproductive Services and Newborn Care” in *Section 5: Covered Services*.)

— Late Claim Filing

This Plan does not cover services of a Nonparticipating Provider if the claim for such services is received by BCBSNM **more than 12 months** after the date of service. (Preferred Providers contracting directly with BCBSNM and providers that have a “participating” provider agreement with BCBSNM will file claims for you and must submit them within a specified period of time, usually 180 days.) If a claim is returned for further information, resubmit it **within 45 days**. **Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change. See *Section 8: Claim Payments and Appeals* for details.

— Learning Deficiencies/Behavioral Problems

This Plan does not cover special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance. See “Autism Spectrum Disorders” in *Section 5: Covered Services* for details about mandated coverage for children with these diagnoses. See *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.

— Limited Services/Covered Charges

This Plan does not cover amounts in excess of covered charges or services that exceed any maximum benefit limits listed in this benefit booklet, or any amendments, riders, addenda, or endorsements.

— Local Anesthesia

This Plan does not cover local anesthesia. (Coverage for surgical, maternity, diagnostic, and other procedures includes an allowance for local anesthesia because it is considered a routine part of the procedure.)

— Long-Term and Maintenance Therapy

This Plan does not cover long-term therapy whether for physical or for mental conditions, even if Medically Necessary and even if any applicable benefit maximum has not yet been reached, except that medication management for chronic conditions is covered. Therapies are considered long-term if measurable improvement is not possible **within two months** of beginning active therapy. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered. (Chronic conditions include, but are not limited to, muscular dystrophy, Down’s syndrome, and cerebral palsy.) **Note:** This exclusion does **not** apply to benefits for medication or medication management or to certain services required to be covered under New Mexico state law for children with autism spectrum disorders.

This Plan does not cover maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved hospice benefit period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation (e.g., medical records, physician’s letters, progress notes) from your physician supporting his/her opinion. **Note:** Even if your rehabilitative potential has not yet been reached, **this Plan does not cover** services that exceed maximum benefit limits.

— Medical Necessity Guidelines Determinations

Any technologies, procedures, or services for which Medical Necessity Guidelines have been developed by BCBSNM are either limited or excluded as defined in the Medical Necessity Guidelines. Exception: The fact that this Plan covers certain services that are excluded under BCBSNM Medical Necessity Guidelines and certain services defined as experimental or as maintenance therapy but which must be covered under New Mexico state law (such as cancer clinical trials and Applied Behavioral Analysis) does not mean that any other services will be or should be covered when contraindicated by BCBSNM Medical Necessity Guidelines. Only those services mandated by state law will be excepted from this BCBSNM standard Medical Necessity Guidelines exclusion.

— Medical Tourism

This Plan does not cover any services and/or supplies provided to a Member outside the United States if the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs.

— Medically Unnecessary Services

This Plan does not cover services that are not Medically Necessary as defined in *Section 5: Covered Services* unless such services are specifically listed as covered (e.g., see “Preventive Services” or “Autism Spectrum Disorders” in *Section 5: Covered Services*).

BCBSNM, in consultation with the provider, determines whether a service or supply is Medically Necessary and whether it is covered. Because a provider prescribes, orders, recommends, or approves a service or supply does *not* make it Medically Necessary or make it a covered service, even if it is not specifically listed as an exclusion. (BCBSNM, at its sole discretion, determines medical necessity based on the criteria given in *Section 5: Covered Services*.)

— No Legal Payment Obligation

This Plan does not cover services for which you have no legal obligation to pay or that are free, including:

- charges made only because benefits are available under this Plan
- services for which you have received a professional or courtesy discount
- volunteer services
- services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member
- physician charges exceeding the amount specified by Centers for Medicare & Medicaid Services (CMS) when primary benefits are payable under Medicare

Note: The “No Legal Payment Obligation” exclusion does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services, and Medicaid, or certain services that are reimbursed to the Department of Health according to the “Early Developmental Delay and Disability” provision in *Section 8: Claim Payments and Appeals*.

— Noncovered Providers of Service

This Plan does not cover services prescribed or administered by a:

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
 - health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
 - school infirmary
 - halfway house
 - massage therapist
 - private sanitarium
 - extended care facility or similar institution
 - residential treatment center (A residential treatment center is a facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization.)
 - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
 - homeopathic or naturopathic provider

— Nonemergency Services

This Plan does not cover nonemergency services outside the United States.

— Nonmedical Expenses

This Plan does not cover nonmedical expenses (even if medically recommended and regardless of therapeutic value), including costs for services or items such as, but not limited to:

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see “Physician Visits/Medical Care” and “Preventive Services” in *Section 5: Covered Services* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; “get-acquainted” visits without physical assessment or medical care; provision of medical information to perform admission review or other preauthorizations; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member’s work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member

— Nonpreferred Provider Services

This Plan does not cover the following services when received from a Nonpreferred Provider: acupuncture, spinal manipulation, outpatient cardiac and pulmonary rehabilitation, inpatient or outpatient physical therapy, speech therapy, occupational therapy, skilled nursing facility services, and transplants.

This Plan does not cover transplants when received from a Nonpreferred Provider.

— Nonprescription Drugs

This Plan does not cover nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for those products specifically listed as covered.

— **Nutritional Supplements**

This Plan does not cover vitamins, dietary/nutritional supplements, special foods, formulas, mother’s milk, or diets, unless prescribed by a physician. Such supplements require a prescription to be covered under the “Home Health Care/Home I.V. Services” in *Section 5: Covered Services*. This Plan covers other nutritional products only under specific conditions set forth under your *Drug Plan Rider*.

— **Obesity Surgery**

This Plan does not cover any and all surgical treatments of obesity including, without limitation, gastric bypass or other type of bariatric surgery, under any circumstance. This is true regardless of the presence or absence of other medical conditions that can be either directly or indirectly attributed to obesity. Obesity means any diagnosis of obesity including morbid obesity.

— **Post-Termination Services**

This Plan does not cover any service received or item or drug purchased after your coverage is terminated, even if: 1) preauthorization for such service, item, or drug was received from BCBSNM, or 2) the service, item, or drug was needed because of an event that occurred while you were covered. (If you are an inpatient when coverage ends, benefits for the admission will be available only for those covered services received before your termination date.)

— **Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products and Special Medical Foods**

You should have received a separately issued *Drug Plan Rider* that explains your benefits for these items. All general limitations and exclusions listed in this *Section 6* also apply to items covered under the *Drug Plan Rider*.

— **Preauthorization Not Obtained When Required**

This Plan does not cover certain services if you do not obtain preauthorization from BCBSNM before those services are received. See *Section 4: Preauthorizations*.

— **Private Duty Nursing Services**

This Plan does not cover private duty nursing services.

— **Psychotherapy (Mental Health and Chemical Dependency)**

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see “Psychotherapy (Mental Health and Chemical Dependency)” in *Section 5: Covered Services* for additional exclusions.

— **Sexual Dysfunction Treatment**

This Plan does not cover services related to the treatment of sexual dysfunction.

— **Supplies, Equipment and Prosthetics**

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see “Supplies, Equipment and Prosthetics” in *Section 5: Covered Services* for additional exclusions.

— **Surgery and Related Services**

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see “Surgery and Related Services” in *Section 5: Covered Services* for additional exclusions.

— Therapy and Counseling Services

This Plan does not cover therapies and counseling programs other than the therapies listed as covered in this benefit booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this section, (see “Rehabilitation and Other Therapy” in *Section 5: Covered Services* for additional exclusions) **this Plan does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management, weight-loss, and codependency programs
- smoking/tobacco use cessation counseling programs of providers that do not meet the standards described under “Cessation Counseling” in *Section 10: Definitions* or that are received from Nonpreferred Providers
- services of a massage therapist or rolfing
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay except as required by federal law and described in *Section 5* under “Autism Spectrum Disorders” (See “Early Developmental Delay and Disability” in *Section 8: Claim Payments and Appeals* for coverage of certain services provided to eligible children by the Department of Health.)
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; except as required by law and described in *Section 5* under “Autism Spectrum Disorders”; other speech services that can be carried out by the patient, the family, or caregiver/teacher

— Thermography

This Plan does not cover thermography (a technique that photographically represents the surface temperatures of the body).

— Transplant Services

Please see “Transplant Services” in *Section 5: Covered Services* for specific transplant services that are covered and related limitations and exclusions. In addition to services excluded by the other general limitations and exclusions listed throughout this section, **this Plan does not cover** any other transplants (or organ-combination transplants) or services related to any other transplants.

— Travel or Transportation

This Plan does not cover travel expenses, even if travel is necessary to receive covered services unless such services are eligible for coverage under “Transplant Services” or “Ambulance Services” in *Section 5: Covered Services*.

— Veteran’s Administration Facility

This Plan does not cover services or supplies furnished by a Veterans Administration facility for a service-connected disability or while a member is in active military service.

— Vision Services

This Plan does not cover any services related to refractive keratoplasty (surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct visual

refractive defect (e.g., farsightedness or astigmatism). **This Plan does not cover** eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under “Supplies, Equipment and Prosthetics” in *Section 5: Covered Services*. **This Plan does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

— **War-Related Conditions**

This Plan does not cover any service required as the result of any act of war or related to an illness or accidental injury sustained during combat or active military service.

— **Weight Management**

This Plan does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment, other than counseling programs as required under federal law unless dietary advice and exercise are provided by a physician, nutritionist, or dietitian licensed by the appropriate agency. Call a Customer Service Advocate for assistance.

— **Work-Related Conditions**

This Plan does not cover services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:

- occupational disease laws
- employer’s liability
- municipal, state, or federal law (except Medicaid)
- Workers’ Compensation Act

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers’ Compensation Act or any of the above provisions that apply, including filing an appeal. (BCBSNM may pay claims during the appeal process on the condition that you sign a reimbursement agreement.)

This Plan does not cover a work-related illness or injury, **even if:**

- You fail to file a claim within the filing period allowed by the applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations.
- You obtain care not authorized by Workers’ Compensation insurance.
- Your employer fails to carry the required Workers’ Compensation insurance. (The employer may be liable for an employee’s work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

Note: This “Work-Related Conditions” exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers’ Compensation Act. You must provide documentation showing that you have waived Workers’ Compensation and are eligible for the waiver. (The Workers’ Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

For a work-related injury or condition, see the “Work-Related Conditions” exclusion in Section 6: General Limitations and Exclusions.

This Plan contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of BCBSNM’s covered charges. (Other valid coverage is defined as all other group and individual (or direct-pay) insurance policies or health care plans including Medicare, but excluding Indian Health Service and Medicaid coverages, that provide payments for medical services and are considered other valid coverage for purposes of coordinating benefits under this Plan.)

If you are also covered by Medicare, special COB rules may apply. Contact a Customer Service Advocate for more information. If you are enrolled in federal continuation coverage, coverage ends at the beginning of the month when you become entitled to Medicare or when you become insured under any other valid coverage.

When this Plan is secondary, all provisions (such as obtaining preauthorization) must be followed or benefits may be denied.

The following rules determine which coverage pays first:

No COB Provision — If the other valid coverage does not include a COB provision, that coverage pays first.

Medicare — If the other valid coverage is Medicare and Medicare is not secondary according to federal law, Medicare pays first.

Child/Spouse — If a covered child under this health plan is covered as a spouse under another health plan, the covered child’s spouse’s health plan is primary over this health plan.

Subscriber/Family Member — If the member who received care is covered as an employee, retiree, or other policy holder (i.e., as the subscriber) under one health plan and as a spouse, child, or other family member under another, the health plan that designates the member as the employee, retiree, or other policy holder (i.e., as the subscriber) pays first.

If you have other valid coverage *and* Medicare, contact the other carrier’s customer service department to find out if the other coverage is primary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may not be subject to those provisions.

Child — For a child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first. If the other valid coverage does not follow this rule, the father’s coverage pays first.

Child, Parents Separated or Divorced — For a child of divorced or separated parents, benefits are coordinated in the following order:

- *Court-Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child’s health care expenses, the coverage of that parent pays first.
- *Custodial/Noncustodial.* The plan of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.
- *Joint Custody.* If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.

Active/Inactive Employee — If a member is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. (Even if a member is covered as a family member under both coverages, the coverage through active employment pays first.) If the other plan does not have this rule and the plans do not agree on the order of benefits, the next rule applies.

Longer/Shorter Length of Coverage — When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of benefits, a change in the entity that pays, provides, or administers the benefits, or a change from one type of plan to another.)

Responsibility For Timely Notice

BCBSNM is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

Whenever any other plan makes benefit payments that should have been made under this Plan, BCBSNM has the right to pay the other plan any amount BCBSNM determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Plan, and with that payment BCBSNM will fully satisfy its liability under this provision.

Overpayments – Right of Recovery

Regardless of who was paid, whenever benefit payments made by BCBSNM exceed the amount necessary to satisfy the intent of this provision, BCBSNM has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organizations or persons.

REIMBURSEMENT

If you or one of your covered family members incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for covered services described in this benefit booklet, you agree:

- BCBSNM has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total covered charged for covered services for which BCBSNM has provided benefits to you or your covered family members.
- BCBSNM is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSNM provided for that sickness or injury.

BCBSNM shall have the right to first reimbursement out of all funds you, your covered family members, or your legal representative, are or were able to obtain for the same expenses for which BCBSNM has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 8: CLAIMS PAYMENTS AND APPEALS

CLAIM FORMS AND PROOF OF LOSS

Written proof of loss must be furnished to BCBSNM in accordance with the Claim procedures specified in this *Section 8: Claims Payments and Appeals*. Proof may be submitted either electronically or on paper. Written notice of Claim must be given to BCBSNM within 365 days after the occurrence or start of the loss on which the Claim is based. If notice is not given in that time, the claim will not be invalidated or denied if it is shown that written notice was given as soon as was reasonably possible. When BCBSNM receives a request for a claim form or the notice of a Claim, BCBSNM will give the Member the claim forms that we use for filing proof of loss. If the claimant does not receive these forms within 15 days after BCBSNM receives notice of claim or the request for a claim form, the claimant will be considered to meet the proof of loss requirements of this Plan if the claimant submits written proof of loss within 365 days after the date of the first service, except in the absence of legal capacity.

IF YOU HAVE OTHER VALID COVERAGE

When you have other valid coverage that is “primary” over this Plan, you need to file your claim with the other coverage first. (See *Section 7: Coordination of Benefits (COB) and Reimbursement*.) After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile, or other liability insurance, Workers’ Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to BCBSNM or to the local BCBS Plan, as instructed under “Where to Send Claim Forms” later in this section.

If the other valid coverage pays benefits to you (or your family member) directly, give your provider a copy of the payment explanation so that he/she can include it with the claim sent to BCBSNM or to the local BCBS Plan. (If a Nonparticipating Provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to BCBSNM or to the local BCBS Plan, as applicable.)

PARTICIPATING AND PREFERRED PROVIDERS

Your “preferred” provider may have two agreements with the local BCBS Plan — a Preferred Provider contract and another Participating Provider contract. Some providers have **only** the Participating Provider contract and are **not** considered Preferred Providers. However, all participating and Preferred Providers file claims with their local BCBS Plan and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. Do **not** file claims for these services yourself.

Preferred Providers (and Participating Providers contracting directly with BCBSNM) also have specific timely filing limits in their contracts with BCBSNM (usually 180 days). The providers’ contract language lets them know that they may not bill the employer or any member for a service if the provider does not meet the filing limit for that service and the claim for that service is denied due to timely filing limitations.

PROVIDER NETWORK

Network providers are not required to comply with any specified numbers, targeted averages, or maximum durations of patient visits. You will not be held liable to a network provider for any sums owed to the provider by BCBSNM.

NONPARTICIPATING PROVIDERS

A Nonparticipating Provider is one that has neither a preferred or a Participating Provider agreement. If your Nonparticipating Provider does not file a claim for you, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other valid coverage’s payment explanation, to a *Member Claim Form*. (Forms can be printed from the BCBSNM website at www.bcbsnm.com or requested from a Customer Service Advocate.) Complete the claim form using the instructions on the form. (See special claim filing instructions for out-of-country claims under “Where to Send Claim Forms” later in this section.)

Payment normally is made to the provider. However, if you have already paid the provider for the services being claimed, your claim must include evidence that the charges were paid in full. Upon approval of the claim, BCBSNM will reimburse you for covered services, based on covered charges, less any required member copayment. You will be responsible for charges not covered by the Plan.

ITEMIZED BILLS

Claims for covered service must be itemized on the provider's billing forms or letterhead stationery and must show:

- member's identification number
- member's and subscriber's name and address
- member's date of birth and relationship to the subscriber
- name, address, National Provider Identification number (NPI), and tax ID or social security number of the provider
- date of service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately)
- accident or surgery date (when applicable)
- amount paid by you (if any) along with a receipt, cancelled check, or other proof of payment

Correctly itemized bills are necessary for your claim to be processed. The only acceptable bills are those from health care providers. Do **not** file bills you prepared yourself, canceled checks, balance due statements, or cash register receipts. Make a copy of all itemized bills for your records before you send them. The bills are not returned to you. All information on the claim and itemized bills must be readable. If information is missing or is not readable, BCBSNM will return it to you or to the provider.

Do not file for the same service twice unless asked to do so by a Customer Service Advocate. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting. (See "Where to Send Claim Forms" below, for special instructions regarding out-of-country claims.)

WHERE TO SEND CLAIM FORMS

If your Nonparticipating Provider does not file a claim for you, you (not the provider) are responsible for filing the claim. **Remember:** Participating and Preferred Providers will file claims for you; these procedures are used only when you must file your own claim.

Services in United States, Canada, Jamaica, U.S. Virgin Islands, and Puerto Rico

If a Nonparticipating Provider will not file a claim for you, ask for an itemized bill and complete a claim form the same way that you would for services received from any other Nonparticipating Provider. Mail the claim forms and itemized bills to BCBSNM at the address below (or, if you prefer, you may send to the local Blue Cross Blue Shield Plan in the state where the services were received):

Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Mental Health/Chemical Dependency Claims

Claims for covered mental health and chemical dependency services received in New Mexico should be submitted to:

BCBSNM, BH Unit
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Drug Plan Claims

If you purchase a prescription drug or other item covered under the drug plan from a nonparticipating pharmacy or other provider in an emergency, or if you do not have your ID card with you when purchasing a prescription or other covered item, you must pay for the prescription in full and then submit a claim to BCBSNM's pharmacy benefit manager. **Do not send these claims to BCBSNM.** The bills or receipts must be issued by the pharmacy and must include the pharmacy name and address, drug name, prescription number, and amount charged. If not included in

your enrollment materials, you can obtain the name and address of the pharmacy benefit manager and the necessary claim forms from a Customer Service Advocate or on the BCBSNM website at www.bcbsnm.com.

Services Outside the United States, U.S. Virgin Islands, Jamaica, Puerto Rico or Canada

For covered inpatient hospital services received outside the United States (including Puerto Rico, Jamaica, and the U.S. Virgin Islands), show your Plan ID card issued by BCBSNM. BCBSNM participates in a claim payment program with the Blue Cross and Blue Shield Association. If the hospital has an agreement with the Association, the hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the hospital by that Plan, and then BCBSNM reimburses the other Plan.

You will need to pay up front for care received from a **doctor, a participating outpatient hospital, and/or a nonparticipating hospital**. Then, complete a Blue Cross Blue Shield Global Core *International Claim Form* and send it with the bill(s) to the service center (the address is on the form). The *International Claim Form* is available from BCBSNM, the service center, or on-line at:

www.bcbs.com/already-a-member/coverage-home-and-away.html

The Blue Cross Blue Shield Global Core *International Claim Form* is to be used to submit institutional and professional claims for benefits for covered emergency services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. For filing instructions for other claim types (e.g., dental, prescription drugs, etc.) contact your Blue Cross and Blue Shield Plan. The *International Claim Form* must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The member should submit an *International Claim Form* (available at www.bcbs.com), attach itemized bills, and mail to Blue Cross Blue Shield Global Core at the address below. Blue Cross Blue Shield Global Core will then translate the information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the claim. Once the claim is finalized, the *Explanation of Benefits* will be mailed to the subscriber and payment, if applicable, will be made to the subscriber via wire transfer or check. Mail international claims to:

**Service Center
P.O. Box 72017
Richmond, VA 23255-2017**

CLAIMS PAYMENT PROVISIONS

Most claims will be evaluated and you and/or the provider notified of the BCBSNM benefit decision within 30 days of receiving the claim. If all information needed to process the claim has been submitted, but BCBSNM cannot make a determination within 30 days, you will be notified (before the expiration of the 30-day period) that an additional 15 days is needed for claim determination.

After a claim has been processed, the subscriber will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not. **Note:** If a Qualified Child Medical Support Order (QCMSO) is in effect, the QCMSO provisions will be followed. For example, when the member is an eligible child of divorced parents, and the subscriber under this Plan is the noncustodial parent, the custodial parent may receive the payment and the EOB.

If A Claim or Preauthorization Is Denied

If benefits are denied or only partially paid, BCBSNM will notify you of the determination. The notice to you will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial. (See "Grievance Procedures," later in this section.) **You also have 180 days in which to appeal a decision.**

Covered Charge

Provider payments are based upon Preferred Provider and Participating Provider agreements and covered charges as determined by BCBSNM. For services received outside of New Mexico, covered charges may be based on the local Plan practice (e.g., for out-of-state providers that contract with their local Blue Cross and Blue Shield Plan, the covered charge may be based upon the amount negotiated by the other Plan with its own contracted providers). You are responsible for paying copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses. For covered emergency services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

Participating and Preferred Providers

Payments for covered services usually are sent directly to network (preferred or participating) providers. The EOB you receive explains the payment.

Nonparticipating Providers

If covered services are received from a Nonparticipating Provider, payments are usually made to the subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses.

Accident-Related Hospital Services

If services are administered as a result of an accident, a hospital or treatment facility may place a lien upon a compromise, settlement, or judgement obtained by you when the facility has not been paid its total billed charges from all other sources.

Assignment of Benefits

BCBSNM specifically reserves the right to pay the subscriber directly and to refuse to honor an assignment of benefits in any circumstances. No person may execute any power of attorney to interfere with BCBSNM's right to pay the subscriber instead of anyone else.

Early Developmental Delay and Disability

For covered children **under age four** who are also eligible for services under the New Mexico Department of Health's (DOH) "Family, Infant and Toddler" (FIT) program, as defined in 7.30.8, NMAC, your BCBSNM Plan will reimburse the DOH for certain medically necessary early intervention services that are provided as part of an individualized family service plan under the FIT program by personnel who are licensed and certified for the DOH's FIT program. The maximum reimbursement under the BCBSNM Plan is **limited to \$3,500** per year. However, amounts paid to DOH for such services are not included in any annual or lifetime benefit maximums under the Plan. Claims for services payable to the DOH under this provision will be honored only if submitted to BCBSNM by the New Mexico DOH.

Medicaid

Payment of benefits for members eligible for Medicaid is made to the appropriate state agency or to the provider when required by law.

Overpayments

If BCBSNM makes an erroneous benefit payment to the subscriber or member for any reason (e.g., provider billing error, claims processing error), BCBSNM may recover overpayments from you. If you do not refund the overpayment, BCBSNM reserves the right to withhold future benefit payments to apply to the amount that you owe the Plan, and to take legal action to correct payments made in error.

Pricing of Non-contracted Provider Claims

The BCBSNM covered charge for some covered services received from non-contracted providers is the lesser of the provider's billed charges or the BCBSNM "noncontracting allowable amount." The BCBSNM noncontracting allowable amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). The Medicare Allowable is determined for a service covered under your BCBSNM health plan using information on each specific claim and, based on place of treatment and date of service, is multiplied by an "adjustment factor" to calculate the BCBSNM noncontracting allowable amount. The adjustment factor for nonemergency services are:

- 100% of the base Medicare Allowable for inpatient facility claims
- 300% of the base Medicare Allowable for outpatient facility claims
- 200% of the base Medicare Allowable for freestanding ambulatory surgical center claims
- 100% of the base Medicare Allowable for physician, other professional provider claims, and other ancillary providers of covered health care services and supplies

Certain categories of claims for **covered services** from non-contracted providers are excluded from this non-contracted provider pricing method. These include:

- services for which a Medicare Allowable cannot be determined based on the information submitted on the claim (in such cases, the covered charge is 50 percent of the billed charge)
- home health claims (the covered charge is 50 percent of the billed charge)
- services administered and priced by any subcontractor of BCBSNM or by the Blue Cross and Blue Shield Association
- claims paid by Medicare as primary coverage and submitted to your health plan for secondary payment
- New Mexico ground ambulance claims (for which the state's New Mexico Public Regulation Commission sets fares)
- covered claims priced by a non-New Mexico BCBS Plan through BlueCard using local pricing methods

Pricing for the following categories of claims for **covered services** from non-contracted providers will be priced at billed charges or at an amount negotiated by BCBSNM with the provider, whichever is less:

- covered services required during an emergency and received in a hospital, trauma center, or ambulance
- for PPO health plans, services from non-contracted providers that satisfy at least one of the three conditions below and, as a result, are eligible for the Preferred Provider benefit level of coverage
 - covered services from non-contracted providers within the United States that are classified as "unsolicited" as explained earlier in *Section 3: How Your Plan Works* and as determined by the member's Host Plan while outside the service area of BCBSNM
 - preauthorized** transition of care services received from non-contracted providers
 - covered services received from a non-contracted anesthesiologist, pathologist, or radiologist while you are a patient at a **contracted** facility receiving covered services or procedures that have been preauthorized, if needed

BCBSNM will use essentially the same claims processing rules and/or edits for non-contracted provider claims that are used for contracted provider claims, which may change the covered charge for a particular service. If BCBSNM does not have any claim edits or rules for a particular covered service, BCBSNM may use the rules or edits used by Medicare in processing the claims. Changes made by CMS to the way services or claims are priced for Medicare will be applied by BCBSNM within 90-145 days of the date that such change is implemented by CMS or its successor.

IMPORTANT: Regardless of the pricing method used, the BCBSNM covered charge will usually be less than the provider’s billed charge and **you will be responsible** for paying to the provider the difference between the BCBSNM covered charge and the non –contracted provider’s billed charge for a covered service. **This difference may be considerable.** The difference is **not** applied to any deductible or out –of –pocket limit. In the case of a noncovered service, you are responsible for paying the provider’s full billed charge directly to the provider. **Reminder:** Contracted providers will **not** charge you the difference between the BCBSNM covered charge and the billed charge for a covered service.

Provider Payment Example

The two examples below demonstrate the difference between your liability for services from a Nonpreferred Provider (when such services are **preauthorized** and **not** eligible for 100 percent coverage of billed charges, such as during an emergency) versus a Preferred Provider. Both examples are for a plan that pays 80 percent of covered charges with the remaining 20 percent of covered charges paid by the member.

Example 1. Preferred Provider Claim Payment (Plan pays 80 percent; deductible is met):

Provider’s billed charge	\$10,000
Covered charges (maximum amount that can be considered for benefit payment)	\$8,000
BCBSNM payment to provider (80% of \$8,000)	\$6,400
Member coinsurance (20% of \$8,000) applied to the out-of-pocket limit	\$1,600
Amount over the covered charges – the Preferred Provider writes off the difference between billed amount and covered charge	\$0
Total amount due from member (coinsurance only):	\$1,600

Example 2. Nonpreferred Provider Claim Payment (Plan pays 80 percent; deductible is met):

Provider’s billed charge	\$10,000
Covered charges (maximum amount that can be considered for benefit payment)	\$8,000
BCBSNM payment to provider (80% of \$8,000)	\$6,400
Member coinsurance (20% of \$8,000) applied to the out-of-pocket limit	\$1,600
Amount over the covered charges – the member is responsible for all costs incurred over the covered charges and these amounts do not apply to your out-of-pocket limits	\$2,000
Total amount due from member (coinsurance only):	\$3,600

<i>Example 3</i>	In-Network Hospital (Plan Pays 90%)	Out-of-Network Hospital (Plan Pays 70%)
Actual Hospital Charge	\$10,500	\$10,500
Amount Recognized by medical plan:	\$6,500 (the discounted rate for health plan)	\$8,800 (the Reasonable & Customary charges based on standard charge for that geographic area) Plan does not recognize the \$1,700 difference between the actual charge and the R&C
Medical plan pays:	90% of the discounted rate: \$6,500 x 90% = \$5,850	70% of the discounted rate: \$8,800 x 70% = \$6,160
Member Pays:	10% of the discounted rate: \$6,500 x 10% = \$650	30% of R&C charges (\$8,800) plus 100% of the amount over R&C (\$1,700): \$2,640 + \$1,700 = \$4,340

INTER-PLAN ARRANGEMENTS

Blue Cross and Blue Shield of New Mexico (BCBSNM) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you obtain health care services outside of the BCBSNM Service Area, the Claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

Inter-Plan Arrangements link the BCBSNM provider network with other individual Blue Cross Blue Shield networks across the country to provide you broad access to Contracted Providers. When you receive care outside of the BCBSNM Service Area, you will receive it from one of two types of Providers. Most Providers have a contractual agreement (i.e., are “Contracted Providers”) with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some Providers (“Non-contracted Providers”) don’t contract with the Host Blue. BCBSNM explains below how BCBSNM pays both kinds of Providers.

You always have the choice to receive services from Contracted or Non-contracted Providers in New Mexico or outside New Mexico, but the difference in the amount you pay may be substantial. When services are received by you outside the state of New Mexico from either Contracted or Non-contracted Providers, the Host Blue will provide BCBSNM with a Covered Charge based on what it uses for its own local Members for services received from either Contracted or Non-contracted Providers in the state where the Host Blue is located.

For purposes of the Inter-Plan Arrangements described in this section, “Covered Charge” means the amount that BCBSNM determines is fair and reasonable for a particular covered and Medically Necessary service, as provided to BCBSNM by a Host Blue. After the Member’s share of the Covered Charge is calculated, BCBSNM will pay the remaining amount of the Covered Charge up to the maximum benefit limitation, if any.

BLUECARD[®] PROGRAM

Services Received from Contracted Providers Outside of New Mexico

Under the BlueCard Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSNM will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Contracted Providers.

Whenever you access Covered Services outside the BCBSNM Service Area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- the billed charges for your Covered Services; or
- the negotiated price or “allowable amount” that the Host Blue makes available to BCBSNM.

If the services are provided by a Contracted Provider of the Host Blue, the Provider will submit your Claims directly to the Host Blue to determine the allowable amount. BCBSNM will use the allowable amount to determine the Covered Charge so that your Claim can be processed timely. The Covered Charge will be an amount up to but not in excess of the allowable amount the Host Blue has passed on to BCBSNM. Because the services were provided by a Contracted Provider, you will receive the benefit of the payment/rate negotiated by the Host Blue with the Provider. As always, you will be responsible for any applicable Deductible, Copay and/or Coinsurance amounts (“Member Share”). The amount that BCBSNM pays together with your Member Share is the total amount the Contracted Provider has contractually agreed to accept as payment in full for the services you have received.

Often, this “allowable amount” will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of past pricing of Claims as noted above. However, such adjustments will not affect the price we use for your Claim because they will not be applied after a Claim has already been paid.

In some cases, BCBSNM may, but is not required to, in its sole discretion, negotiate a payment with a non-contracting health care Provider on an exception basis.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your liability calculation.

Services Received from a Non-contracted Provider Outside of New Mexico

If the services are provided by a Non-contracted Provider, the Provider may, but is not required to, submit Claims on your behalf. A Non-contracted Provider has not negotiated its payments/rates with either the Host Blue or BCBSNM. If the Non-contracted Provider does not submit Claims on your behalf, you will be required to submit the Claims directly to the Host Blue. You will be subject to balance billing when you receive services from a Non-contracted Provider. This amount may be significant. "Balance billing" means that the Non-contracted Provider may require you to pay any amount that the Provider bills that exceeds the sum of what BCBSNM pays toward the Covered Charge and your Member Share of the Covered Charge.

Member Liability Calculation

- **In General**

Under Inter-Plan Arrangements, when services are received outside the state of New Mexico from a Non-contracted Provider, the Covered Charge will be determined by the Host Blue servicing the area or by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations and will be passed on to BCBSNM. BCBSNM will use the Host Blue's Covered Charge as its Covered Charge so that your Claim can be processed timely. BCBSNM's Covered Charge will be an amount up to but not in excess of the Covered Charge the Host Blue has passed on to BCBSNM. In addition to being responsible to pay your Member Share, you may be subject to balance billing by the Non-contracted Provider who provided services to you. Before you receive services from a Non-contracted Provider, you should ask for a written breakdown of all amounts that you will have to pay, including Member Share and balance billing amounts for the services you will receive. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

- **Exceptions**

In certain situations, BCBSNM may use other payment bases, to determine the amount BCBSNM will pay for services rendered by Non-contracted healthcare providers, such as (i) billed charges for Covered Services, (ii) the payment we would make if the health care services had been obtained within our Service Area, (iii) a special negotiated payment, as permitted under the Inter-Plan Arrangements policies, or (iv) for Professional Providers, make a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or (v) for Hospital or Facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or Facility. In these situations, you the Member may be responsible for the difference between the amount that the Non-contracted Provider bills and the payment BCBSNM will make for the Covered Services as set forth in this paragraph.

INTER-PLAN ARRANGEMENTS: FEDERAL/STATE TAXES/SURCHARGES/FEEES

Federal or state laws or regulations may impose a surcharge, tax, or other fee. If applicable, BCBSNM will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

SPECIAL CASES: VALUE-BASED PROGRAMS

If you received Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or care coordinator feed that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSNM through average pricing or fee schedule adjustments. Additional information available upon request.

BLUE CROSS BLUE SHIELD GLOBAL CORE

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard Service Area”), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and Professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the service center at 1-800-810-BLUE (2583), or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

For services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine the Covered Charge.

Emergency Care Services

This Plan covers only limited health care services received outside of the United States. As used in this section, “Out-of-Area Covered Services” include Emergency services and Urgent Care obtained outside of the United States. Follow-up care following an Emergency is also available provided the services are Preauthorized by BCBSNM. Any other services will not be eligible for Benefits unless Preauthorized by BCBSNM.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts (Deductibles, Coinsurance, etc.). In such cases, the hospital will submit your Claims to the service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. You must contact BCBSNM to obtain Preauthorization for non-emergency inpatient services.

- **Outpatient Services**

Outpatient services are available for Emergency Care treatment. Physicians, Urgent Care centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard Service Area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider’s itemized bill(s) to the service center (the address is on the form) to initiate Claim processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from BCBSNM, the service center, or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week.

MEMBER DATA SHARE

You may, under certain circumstances as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by BCBSNM, a division of Health Care Service Corporation, or, if you do not reside in the BCBSNM service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various ways, such as from involuntary termination of your health coverage sponsored by the subscriber. As part of the overall plan of benefits that BCBSNM offers to you if you do not reside in the BCBSNM service area, BCBSNM may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this, BCBSNM may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside with your personal information and may

also provide other general information relating to your coverage under the Plan the subscriber has with BCBSNM to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

External Appeal for ERISA Plans

This Plan provided by your group may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). Therefore, if you are still not satisfied after having completed the reconsideration or appeal process administered by BCBSNM, you may have a right to bring a civil action under ERISA section 502(a).

SUMMARY OF HEALTH INSURANCE GRIEVANCE PROCEDURES

Unless otherwise specified below: 1.) any reference to 1-5 days means only working days and excludes weekends and holidays; and 2.) any reference to 6 days or more means calendar days, including weekends and holidays.

This is a summary of the process you must follow when you request a review of a decision by your insurer. You will be provided with detailed information and complaint forms by your insurer at each step. In addition, you can review the complete New Mexico regulations that control the process under the Managed Health Care Bureau page found under the Departments Legal tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. You may also request a copy from your insurer at:

Blue Cross Blue Shield of New Mexico

P.O. Box 27630

Albuquerque, NM 87125-7630

or from OSI by calling:

1-505-827-4601 or toll free at 1-855-427-5674

What types of decisions can be reviewed?

You may request a review of two different types of decisions:

Adverse determination: You may request a review if your insurer has denied preauthorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (The insurer must notify you *before* terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by the insurer of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called "**adverse determinations.**"

Administrative decision: You may also request a review if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

REVIEW OF AN ADVERSE DETERMINATION

How does pre-authorization for a health care service work?

When your insurer receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process.

Coverage: First, the insurer determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for adult hearing aids, then your insurer will not agree to pay for you to have them even if you have a clear need for them.

Medical Necessity: Next, if the insurer finds that the requested service is covered by the policy, the insurer determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the insurer. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that your insurer pay for cosmetic plastic surgery to give you a more attractive nose, the insurer might certify the first request to repair your hand and deny the second, because it is not medically necessary.

Depending on terms of your policy, your insurer might also deny certification if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, the insurer may deny certification. Your insurer might also deny certification if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If your insurer determines that it will not certify your request for services, you may still go forward with the treatment or procedure. However, you will be responsible for paying the provider yourself for the services.

How long does initial certification take?

Standard decision: The insurer must make an initial decision within 5 working days. However, the insurer may extend the review period for a maximum of 10 calendar days if it: (1) can demonstrate reasonable cause beyond its control for the delay; (2) can demonstrate that the delay will not result in increased medical risk to you; and (3) provides a written progress report and explanation for the delay to you and your provider within the original 5 working day review period.

What if I need services in a hurry?

Urgent care situation: An **urgent care situation** is a situation in which a decision from the insurer is needed quickly because: (1) delay would jeopardize your life or health; (2) delay would jeopardize your ability to regain maximum function; (3) your provider **reasonably** requests an expedited decision; (4) the physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or (5) the medical demands of your case require an expedited decision.

If you are facing an urgent care situation **or** your insurer has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and the insurer must either certify or deny the initial request quickly. The insurer must make its initial decision in accordance with the medical demands of the case, but within 24 hours of the written or verbal receipt of the request for an **expedited** decision.

If you are dissatisfied with the insurer's initial expedited decision in an urgent care situation, you may then request an expedited review of the insurer's decision by both the insurer and an external reviewer called an Independent Review Organization (IRO). When an expedited review is requested the insurer must review its prior decision and respond to your request within 72 hours. If you request that an IRO also perform an expedited review simultaneously with the insurer's review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours of receiving the necessary release of information and related records. If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within 72 hours after your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide you through the claims process once the emergency has passed.

When will I be notified that my initial request has been either certified or denied?

If the initial request is approved, the insurer must notify you and your provider within 1 working day after the decision, unless an urgent matter requires a quicker notice. If the insurer denies certification, the insurer must notify you and the provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer as well as forms and detailed instructions for requesting a review. **You may submit the request for review either orally or in writing depending on the terms of your policy.** The insurer provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the insurer's consumer assistance office as follows.

Blue Cross Blue Shield of New Mexico

P.O. Box 27630

Albuquerque, NM 87125-7630

Medical/Surgical 1-800-205-9926

Mental Health/Chemical Dependency 1-888-898-0010

Fax (505) 816-3837 or toll free at (800) 773-1521

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing the written request for a review at:

Office of Superintendent of Insurance – MHCB

P.O. Box 1689, 1120 Paseo de Peralta

Santa Fe, NM 87504-1689

1-(505) 827-4601 or toll free at 1-(855) 407-5674

Fax: (505) 827-6341, Attn: MHCB

Email: mhcb.grievance@state.nm.us

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **“grievant.”**

Appealing an adverse determination – first level review

If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director. The medical director may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify the insurer that you wish to request in internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that the insurer review its decision, the insurer will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?

Expedited review: If a review request involves an urgent care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review: Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within 30 days after receipt of your pre-service request for review or within 60 days if you have already received the services. The medical director's review generally takes only a few days.

The medical director denied my request – now what?

If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by the insurer or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.

- If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider, and ask questions of the panel members. Your health provider may also address the panel or send a written statement.
- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

IMPORTANT: If you are covered under the NM State Healthcare Purchasing Act, you may NOT request an IRO review if you skip the panel review.

How long do I have to make my decision?

If you wish to have your request reviewed by the insurer's panel, you must inform the insurer within **5 days** after you receive the medical director's decision. If you wish to skip the insurer's panel review and have your matter go directly to the IRO, you must inform OSI of your decision within **4 months** after you receive the medical director's decision.

What happens during a panel review?

If you request that the insurer provide a panel review its decision, the insurer will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because the insurer felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

The insurer will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone, or arrange to have someone attend with you or on your behalf. You may review all of the information that the insurer will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone may address the panel or send a written statement.

The insurer's internal panel must complete its review within 30 days following your original request for an internal review of a request for pre-certification or within 60 days following your original request if you already received the services. You will be notified within 1 day after the panel decision. If you fail to provide records or other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

HINT: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of 30 days.

If I choose to have my request reviewed by the insurer's panel, can I still request the IRO review?

Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have **4 months** to decide whether you want to have the request reviewed by an IRO.

What's an IRO and what does it do?

An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI

selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with the insurer or with you. The reviewer will consider all of the information that is provided by the insurer and by you. (OSI can assist you in getting your information to the IRO) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, your insurer, and to OSI. Your insurer must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then the insurer must provide them.

The IRO's fees are billed directly to the insurer – there is no charge to you for this service.

How long does an IRO review take?

The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (however, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance

If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within 30 days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to the insurer. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

REVIEW OF AN ADMINISTRATIVE DECISION

How long do I have to decide if I want to appeal and how do I start the process?

If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within 180 days after the date you are notified of the decision. The insurer will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

The insurer will mail a decision to you within 30 days after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have 20 days to request that the insurer from a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When the insurer receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after the insurer receives your request. You will be notified at least 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to 30 days.

The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827- 4601 or toll free at 1- (855)- 427- 5674.

How does the external review work?

Upon receipt of your request, the Superintendent will request that both you and the insurer submit information for consideration. The insurer has 5 days to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and the insurer and issue a final decision within 45 days. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

GENERAL INFORMATION

Confidentiality

Any person who comes into contact with your personal health care records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulation.

Reporting requirements

Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

The preceding summary has been provided by the Office of Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

SECTION 9: GENERAL PROVISIONS

APPLICATION STATEMENT

No statement (except a fraudulent statement) you make in any application for coverage that is **more than two years old** can void this coverage or be used against you in any legal action or proceeding relating to this coverage unless the application or a true copy of it is incorporated in or attached to the contract.

AVAILABILITY OF PROVIDER SERVICES

BCBSNM does not guarantee that a certain type of room or service will be available at any hospital or other facility within the BCBSNM network, nor that the services of a particular hospital, physician, or other provider will be available.

CATASTROPHIC EVENTS

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond BCBSNM's control, BCBSNM may be unable to process claims or provide preauthorization for services on a timely basis. If due to circumstances not within the control of BCBSNM or a network provider (such as partial or complete destruction of facilities, war, riot, disability of a network provider, or similar case), BCBSNM and the provider will have no liability or obligation if medical services are delayed or not provided. BCBSNM and its network providers will, however, make a good-faith effort to provide services.

CHANGES TO THE BENEFIT BOOKLET

BCBSNM may amend this benefit booklet when authorized by an officer of BCBSNM. BCBSNM will give your group at least 30 days prior written notice of an amendment to this benefit booklet. No employee of BCBSNM may change this Benefit Booklet by giving incomplete or incorrect information, or by contradicting the terms of this Benefit Booklet. Any such situation will not prevent BCBSNM from administering this Benefit Booklet in strict accordance with its terms. See the inside back cover for further information.

CONSUMER ADVISORY BOARD

BCBSNM has established a Consumer Advisory Board to provide input from the member's point-of-view about BCBSNM's general operations and internal policies and to identify areas that need improvement.

DISABLED CHILDREN CONTINUED COVERAGE

BCBSNM, which provides coverage of an eligible child of the subscriber until the attainment of the limiting age of 26 for eligible children, shall not terminate the coverage of a child while the child is, and continues to be both incapable of self-sustaining employment, by reason of mental retardation or physical disability, and chiefly dependent upon the subscriber for support and maintenance. However, proof of the incapacity and dependency of the child must be furnished to BCBSNM by the subscriber within 31 days of the child's attainment of the limiting age and subsequently, as may be required by BCBSNM, but not more frequently than annually after the two-year period following the child's attainment of the limiting age of 26.

DISCLAIMER OF LIABILITY

BCBSNM has no control over any diagnosis, treatment, care, or other service provided to you by any facility or professional provider, whether preferred or not. BCBSNM is not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

Nothing in this benefit booklet is intended to limit, restrict, or waive any member rights under the law and all such rights are reserved to the individual.

DISCLOSURE AND RELEASE OF INFORMATION

BCBSNM will only disclose information as permitted or required under state and federal law.

ENTIRE CONTRACT

This Benefit Booklet (and any amendments, riders, endorsements, and the *Summary of Benefits*), your Group enrollment/change application, and your Identification (ID) Card shall constitute the entire contract. All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application for coverage.

EXECUTION OF PAPERS

On behalf of yourself and your eligible family members you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this Plan.

FREEDOM OF CHOICE OF HOSPITAL AND PRACTITIONER

Within the area and limits of coverage offered to subscribers and selected by the subscriber in the application for insurance, the right of a person to exercise full freedom of choice in the selection of a hospital for hospital care or of a practitioner of the healing arts, or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, or registered nurse in expanded practice, for treatment of an illness or injury within that practitioner's scope of practice shall not be restricted under any new policy of health insurance, contract, or health care plan. Any person insured or claiming benefits under any such health insurance policy, contract, or health care plan providing within its coverage for payment of covered service benefits, or indemnity for hospital care or treatment of persons for the cure or correction of any physical or mental condition shall be deemed to have complied with the Plan requirements as to submission of proof of loss upon submitting written proof supported by the certificate of any hospital currently licensed by the department of health or any practitioner of the healing arts, or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice.

FREEDOM OF CHOICE OF INDEPENDENT SOCIAL WORKER

Within the area and limits of coverage offered to subscribers and selected by the subscriber in the application for insurance, the right of a person to exercise full freedom of choice in the selection of any independent social worker for treatment within that practitioner's scope of practice shall not be restricted under any new policy of health insurance, contract, or health care plan in this state or in the processing of any claim thereunder. Any person insured or claiming benefits under any such health insurance policy, contract, or health care plan providing within its coverage for payment of covered service benefits, or indemnity for treatment of persons for the cure or correction of any mental condition shall be deemed to have complied with the Plan requirements as to submission of proof of loss upon submitting written proof supported by any independent social worker.

INDEPENDENT CONTRACTORS

The relationship between BCBSNM and its network providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any network provider. BCBSNM will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any network provider.

The relationship between BCBSNM and the group is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of the group.

MEMBER RIGHTS

All members have these rights:

- The right to available and accessible services, when Medically Necessary, as determined by your primary care or treating Physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or urgent or Emergency Care services, and for other health services as defined by your Benefit Booklet.
- The right to receive information about BCBSNM, our services, practitioners and providers and member rights and responsibility.
- The right to participate with practitioners in making decisions about your health care.
- The right to make recommendations regarding BCBSNM's member rights and responsibility policy.

- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
- The right to all the rights afforded by law, rule, or regulation as a patient in a licensed Health Care Facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to prompt notification of termination or changes in benefits, services or Provider network.
- The right to file a complaint or appeal with BCBSNM or with the Office of Superintendent of Insurance and to receive an answer to those complaints within a reasonable time.
- The right to request information about any financial arrangements or provisions between BCBSNM and its Preferred Providers that may restrict referral or treatment options or limit the services offered to Members.
- The right to adequate access to qualified health professionals near your work or home within the BCBSNM service area (the state of New Mexico).
- The right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a Nonpreferred Provider, and an explanation of your financial responsibility when services are provided by a Nonpreferred Provider, or provided without required preauthorization.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for preauthorization and utilization review.
- The right to make recommendations regarding BCBSNM's member rights and responsibilities policies.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review and the right to a secondary appeal and the right to request the assistance of the Superintendent of Insurance.

MEMBER RESPONSIBILITIES

As a member enrolled in a managed health care plan administered by BCBSNM, you have these responsibilities:

- The responsibility to supply information (to the extent possible) that BCBSNM and its preferred practitioners and providers need in order to provide care.
- The responsibility to follow plans and instructions for care that you have agreed on with your treating provider or practitioners.
- The responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals with your treating provider or practitioner to the degree possible.

MEMBERSHIP RECORDS

BCBSNM will keep membership records and the employer will periodically forward information to BCBSNM to administer the benefits of this Plan. You can inspect all records concerning your membership in this Plan during normal business hours given reasonable advance notice.

RESEARCH FEES

BCBSNM reserves the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms. If BCBSNM requires an independent medical examination (IME) before authorizing a service or processing a claim, BCBSNM will cover the cost of the IME. In the unlikely event that BCBSNM requires an autopsy before paying a claim, BCBSNM will pay the cost of the autopsy.

PAYMENT OF CLAIMS

Claims submitted by a member for covered services received by a deceased member will be payable in accordance with the beneficiary designation and the provisions respecting such payments and effective at the time of payment. If no such designation or provision is then effective, claims will be payable to the estate of the subscriber. Any other claims unpaid at the member's death may, at our option, be paid to the beneficiary. All other claims will be payable to the subscriber.

PHYSICAL EXAMINATION AND AUTOPSY

If BCBSNM requires an independent medical examination before authorizing a service or processing a claim, BCBSNM will cover the cost of the independent medical examination. In the unlikely event that BCBSNM requires an autopsy before paying a claim, BCBSNM will pay the cost of the autopsy where it is not forbidden by law.

SENDING NOTICES

All notices to you are considered to be sent to and received by you when deposited in the United States mail with first-class postage prepaid and addressed to the subscriber at the latest address on BCBSNM membership records or to the employer.

TIME PAYMENT OF CLAIMS

Claims payable under this Plan for any loss other than loss for which this Plan provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued claims for loss for which this Plan provides periodic payment will be paid not less frequently than monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

TRANSFER OF BENEFITS

All documents described in this booklet are personal to the member. Neither these benefits nor health care plan payments may be transferred or given to any person, corporation, or entity. Any attempted transfer will be void. Use of benefits by anyone other than a member will be considered fraud or material misrepresentation in the use of services or facilities, which may result in cancellation of coverage for the member and appropriate legal action by BCBSNM.

SECTION 10: DEFINITIONS

It is important for you to understand the meaning of the following terms. The definition of many terms determines your benefit eligibility.

Accidental Injury — A bodily injury caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection, hernia or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an accidental injury.

Acupuncture — The use of needles inserted into the human body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition.

Adjustment Factor — The percentage by which the Medicare Allowable amount is multiplied in order to arrive at the “non-contracting allowable amount.” (See definition of “Covered charge.”) Adjustment factors will be evaluated and updated no less than every two years.

Admission — The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.)

Adverse Determination — A decision made either pre-service or post-service by BCBSNM that a health care service requested by a provider or member has been reviewed and based upon the information available does not meet the requirements for coverage or medical necessity and the requested health care service is either denied or terminated.

Alcohol Abuse — Conditions defined by patterns of usage that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol. Alcohol abuse may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol is discontinued.

Alcohol Abuse Treatment Facility, Alcohol Abuse Treatment Program — An appropriately licensed provider of medical detoxification and rehabilitation treatment for alcohol abuse.

Ambulance — A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Ambulatory Surgical Facility — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*
- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

Appliance — A device used to provide a functional or therapeutic effect.

Applied Behavioral Analysis (ABA) — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, “maladaptive” behaviors.

Autism Spectrum Disorder (ASD) — A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as *DSM-IV-TR*, published by the American Psychiatric Association, including autistic disorder;

Asperger's disorder; pervasive development disorder not otherwise specified; Rhett's disorder; and childhood integrative disorder.

Benefit Booklet — This document or evidence of coverage issued to you along with your separately issued *Summary of Benefits*, explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Benefit Program Application (BPA) — The application for coverage completed by the Group and made a part of the Group Contract.

Blue Access for Members (BAM) — On-line programs and tools that BCBSNM offers its members to help track claims payments, make health care choices, and reduce health care costs. For details, see *Section 1: How To Use This Benefit Booklet*.

BlueCard — BlueCard is a national program that enables members of one Blue company to obtain healthcare services while traveling or living in another Blue company's service area. The program links participating healthcare providers with the independent Blue companies across the country and in more than 200 countries and territories worldwide., through a single electronic network for claims processing and reimbursement.

BlueCard Access — The term used by Blue Cross and Blue Shield companies for national doctor and hospital finder resources available through the Blue Cross and Blue Shield Association. These provider location tools are useful when you need covered health care outside New Mexico. Call BlueCard Access at 1 (800) 810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder at www.bcbsnm.com.

Blue Cross and Blue Shield of New Mexico — A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association; also referred to as BCBSNM.

Calendar Year — A Calendar Year (also known as a benefit period) is a period of one year that begins on January 1 and ends on December 31 of the same year (also referred to as a Calendar Year). The initial Calendar Year benefit period is from a member's effective date of coverage and ends on December 31, which may be less than 12 months.

Cancer Clinical Trial — A course of treatment provided to a patient for the prevention of reoccurrence, early detection or treatment of cancer for which standard cancer treatment has not been effective or does not exist. It does not include trials designed to test toxicity or disease pathophysiology, but must have a therapeutic intent and be provided as part of a study being conducted in a cancer clinical trial in New Mexico. The scientific study must have been approved by an institutional review board that has an active federal-wide assurance of protection for human subjects and include all of the following: specific goals, a rationale and background for the study, criteria for patient selection, specific direction for administering the therapy or intervention and for monitoring patients, a definition of quantitative measures for determining treatment response, methods for documenting and treating adverse reactions, and a reasonable expectation based on clinical or pre-clinical data, that the treatment will be at least as effective as standard cancer treatment. The trial must have been approved by a United States federal agency or by a qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

Cardiac Rehabilitation — An individualized, supervised physical reconditioning exercise session lasting 4-12 weeks. Also includes education on nutrition and heart disease.

Certified Nurse-Midwife — A person who is licensed by the Board of Nursing as a registered nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a certified nurse-midwife.

Certified Nurse Practitioner — A registered nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the Board of Nursing.

Cessation Counseling — As applied to the “smoking/tobacco use cessation” benefit described in *Section 5: Covered Services*, under “Preventive Services,” cessation counseling means a program, including individual, group, or proactive telephone quit line, that:

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information, and follow-up;
- operates under a written program outline that meets minimum requirements established by the Office of Superintendent of Insurance;
- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

Chemical Dependency — Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol, drugs or other substance. Chemical dependency (also referred to as “substance abuse,” which includes alcohol or drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol, drugs, or other substance is discontinued.

Chemotherapy — Drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Child — See definition of “Eligible Family Member” in *Section 2: Enrollment and Termination Information*.

Chiropractor Services — Any service or supply administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico or the state in which services are rendered.

Chiropractor — A person who is a doctor of chiropractic (D.C.) licensed by the appropriate governmental agency to practice chiropractic medicine.

Church Plan — That term as defined pursuant to Section 3(33) of the federal Employee Retirement Income Security Act of 1974.

Claim — The term “claim,” as used for this document, refers only to post-service bills for services already received and sent to BCBSNM (or its designee) for benefit determination.

Claims Administrator — BCBSNM which is the entity providing consulting services in connection with the operation of this benefit plan, including the processing and payment of claims and other such functions as agreed to from time to time by your Group and BCBSNM.

Clinical Psychologist — A person with a doctoral degree in clinical psychology licensed or certified in accordance with the New Mexico Professional Psychologist Act or similar statute in another state.

Coinsurance — A percentage of covered charges that you are required to pay for a covered service. For covered services that are subject to coinsurance, you pay the percentage (indicated on the *Summary of Benefits*) of BCBSNM’s covered charge after the deductible (if any) has been met.

Contracted — A provider that has a contract with BCBSNM or another BCBS Plan to bill BCBSNM (or other BCBS Plan) directly and to accept this health plan’s payment (provided in accordance with the provisions of the contract) plus the member’s share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. Also see “Network provider (in-network provider),” in this section.

Copayment — The fixed-dollar amount (or, in some cases, a percentage) that you must pay to a health care provider upfront in order to receive a specific service or benefit covered under this Plan. Copayments are listed on the *Summary of Benefits*.

Cosmetic Surgery Services — Cosmetic surgery services is a beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristics.

Cost Effective — A procedure, service, or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.

Covered Charge — The amount that BCBSNM allows for covered services using a variety of pricing methods and based on generally accepted claim coding rules. The covered charge for services from “contracted providers” is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this health plan. For information about pricing of non-contracted provider claims, see “Pricing of Non-contracted Provider Claims” in *Section 8: Claim Payments and Appeals*.

Noncontracting Allowable Amount — The maximum amount, not to exceed billed charges, that will be allowed for a covered service received from a non-contracted provider in most cases. The BCBSNM non-contracting allowable amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS).

Medicare Allowable — The amount allowed by CMS for Medicare-Participating Provider services, which is also used as a base for calculating non-contracted provider claims payments for some covered services of non-contracted providers under this health plan. The Medicare Allowable amount will not include any additional payments that are not directly tied to a specific claim, for example, medical education payments. If Medicare is primary over this health plan, and has paid for a service, the covered charge under this health plan may be one of the two following amounts:

Medicare-Approved Amount — The Medicare fee schedule amount upon which Medicare bases its payments. When Medicare is the primary carrier, it is the amount used to calculate secondary benefits under this health plan when no “Medicare limiting charge” is available. The Medicare-approved amount may be less than the billed charge.

Medicare Limiting Charge — As determined by Medicare, the limit on the amount that a Nonparticipating Provider can charge a Medicare beneficiary for some services. When Medicare is the primary carrier and a limiting charge has been calculated by Medicare, this is the amount used to determine your secondary benefits under this health plan. **Note:** Not all Medicare-covered services from Nonparticipating Providers are restricted by a Medicare limiting charge.

Covered Services — Those services and other items for which benefits are available under the terms of the benefit plan of an eligible plan member.

Creditable Coverage — Health care coverage through an employment-based group health care plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely benefits pursuant to section 1928 of that title; 10 USCA Chapter 55 (military benefits); a medical care program of the Indian Health Service or of an Indian nation, tribe, or pueblo; the NM Medical Insurance Pool (NMMIP) Act, or similar state sponsored health insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

Custodial Care Services — Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial care includes those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.), and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Cytological Screening — A papanicolaou test or liquid-based cervical cytopathology, a human papillomavirus test, and a pelvic exam for symptomatic, as well as, asymptomatic female patients.

Deductible — The amount of covered charges that you must pay in a Calendar Year before this Plan begins to pay its share of covered charges you incur during the same benefit period. If the deductible amount remains the same during the Calendar Year, you pay it only once each Calendar Year and it applies to all covered services you receive during that Calendar Year. (There is no annual deductible to meet for services of a Preferred Provider.)

Dental-Related Services — Services performed for treatment or conditions related to the teeth or structures supporting the teeth.

Dentist, Oral Surgeon — A doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, accidental injuries and malformation of the teeth, jaws, and mouth.

Diagnostic Services — Procedures such as laboratory and pathology tests, x-ray services, EKGs and EEGs that do not require the use of an operating or recovery room and that are ordered by a provider to determine a condition or disease.

Dialysis — The treatment of a kidney ailment during which impurities are mechanically removed from the body with dialysis equipment.

Doctor of Oriental Medicine — A person who is a doctor of oriental medicine (D.O.M.) licensed by the appropriate governmental agency to practice acupuncture and oriental medicine.

Domestic Partner — A person of the same or opposite sex who meets all of the following criteria:

- shares your permanent residence and has resided with you for no less than one year;
- is not less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to BCBSNM on request.

In addition, you and your Domestic Partner will meet the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within 12 months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse, or spouse equivalent of the same or opposite sex.

Drug Abuse — A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other non-alcoholic substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs is discontinued. Drug Abuse does not include nicotine addiction or alcohol abuse.

Drug Abuse Treatment Facility — An appropriately licensed provider primarily engaged in detoxification and rehabilitation treatment for chemical dependency.

Drug List — A list of prescription drugs that are preferred for use by BCBSNM for retail and mail-order pharmacy benefits. The list is subject to periodic review and change by BCBSNM. BCBSNM-contracted providers should have

received a copy of the list. If you need a list of commonly prescribed drugs on the BCBSNM Drug List, request it from a Customer Service Advocate or visit the BCBSNM website. Your drug plan may or may not use a Drug List. See your separately issued *Drug Plan Rider* for details.

Drug Plan Rider — The document that explains the coverage available to you for prescription drugs, insulin, diabetic supplies, and certain nutritional products.

Durable Medical Equipment — Any equipment that can withstand repeated use, is made to serve a medical purpose, and is generally considered useless to a person who is not ill or injured.

Effective Date of Coverage — 12:01 a.m. of the date on which a member's coverage under this plan begins.

Eligible Child — The following family Members of the Subscriber through the end of the month during which the Child turns age 26:

- natural or legally adopted Child of the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner
- Child placed in the Subscriber's home for purposes of adoption (including a Child for whom the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner is a party in a suit in which the adoption of the Child by the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner is being sought)
- stepchild of the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner
- Child for whom the Subscriber, Subscriber's spouse, or the Subscriber's Domestic Partner must provide coverage because of a court order or administrative order pursuant to state law

Eligible Family Members — Family members of the subscriber, limited to the following:

- the subscriber's legal **spouse**
- the subscriber's **domestic partner** (NOTE: Domestic partner coverage is available at your employer's discretion. Contact your employer for information on whether domestic partner coverage is available for your group.)
- the subscriber's eligible **child** or the eligible child of the subscriber's spouse or subscriber's domestic partner through the end of the month in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from coverage and rates adjusted accordingly - unless the child is an eligible family member under this Plan due to a disability as described below.)
- the subscriber's **unmarried** child or the unmarried child of the subscriber's spouse or subscriber's domestic partner age 26 or older who was enrolled as the subscriber's covered child in this Plan at the time of reaching the age limit, and who is medically certified as **disabled**, chiefly dependent upon the subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability (Such condition must be certified by a Physician and BCBSNM. Also, a child may continue to be eligible for coverage age 26 or older only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition within 31 days of the child's attainment of the limiting age.)

Emergency, Emergency Care — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. In addition, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency. Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Employee Probationary Period — The number of months or days of continuous employment beginning with the employee's most recent date of hire and ending on the date the employee first becomes eligible for coverage under the employer's group. Your employer determines the length of the probationary period.

Enteral Nutritional Products — A product designed to provide calories, protein, and essential micronutrients by the enteral route (i.e., by the gastrointestinal tract, which includes the stomach and small intestine only).

Experimental, Investigational or Unproven — Any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental. To be considered standard medical practice and not experimental or investigational, treatment must meet all five of the following criteria:

- a technology must have final approval from the appropriate regulatory government bodies; however, approval by a governmental or regulatory agency will be taken into consideration by BCBSNM in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative;
- the scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- the technology must improve the net health outcome;
- the technology must be as beneficial as any established alternatives; and
- the improvement must be attainable outside the investigational settings.

Facility — A hospital (see “Hospital” later in this section) or other institution (also, see “Provider” later in this section).

FDA — The United States Food and Drug Administration.

Genetic Inborn Error of Metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

Good Cause — Failure of the subscriber to pay the premiums or other applicable charges for coverage; a material failure to abide by the rules, policies, or procedures of this Plan; or fraud or material misrepresentation affecting coverage.

Governmental Plan — That term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal governmental plan (a governmental plan established or maintained for its employees by the United States government or an instrumentality of that government).

Group — A bonafide employer covering employees of such employer for the benefit of persons other than the employer; or an association, including a labor union, that has a constitution and bylaws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

Group Contract — The group administration document the Group’s application to the Plan (Benefit Program Application), this Benefit Booklet, the Summary of Benefits and Coverage, and any other applications, riders, enclosures, addenda exhibits, and Amendments, or Endorsements, if any, between the Plan and the Group, referred to as the Group Contract.

Group Health Care Plan — An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care (directly or through insurance, reimbursement, or otherwise) to employees or their eligible family members (as defined under the terms of the Plan).

Group Master Application — The application for coverage completed by the employer (or association representative).

Group Master Contract — A contract for health care services which by its terms limits eligibility to members of a specified group. The Group Master Contract includes the group master application and may include coverage for eligible family members.

Habilitative Services — Occupational Therapy, Physical Therapy, Speech Therapy and other health care services that help you keep, learn, or improve skills and functioning for daily living, as prescribed by your Physician pursuant to a treatment plan. Examples include therapy for a child who isn’t walking or talking at the expected age and includes

therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired Disorder. These pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this benefit booklet.

Health Care Benefits — Benefits for Medically Necessary services consisting of preventive care, emergency care, inpatient and out-patient hospital and Physician care, diagnostic laboratory and diagnostic and therapeutic radiological services and does not include dental services, vision services for adults, or long-term rehabilitation treatment.

Health Care Facility — An institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing facility, a residential treatment center, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

Home Health Care Agency — An appropriately licensed provider that both:

- brings skilled nursing care and other services on an intermittent, visiting basis into your home in accordance with the licensing regulations for home health care agencies in New Mexico or in the state where the services are provided; *and*
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending physician.

Home Health Care Services — Covered services, as listed under “Home Health Care/Home I.V. Services” in *Section 5: Covered Services*, that are provided in the home according to a treatment plan by a certified home health care agency under active physician and nursing management. Registered nurses must coordinate the services on behalf of the home health care agency and the patient’s physician.

Hospice — A licensed program providing care and support to terminally ill patients and their families. An approved hospice must be licensed when required, Medicare-certified as, or accredited by, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), as a hospice.

Hospice Benefit Period — The period of time during which hospice benefits are available. It begins on the date the attending physician certifies that the member is terminally ill and ends **six months** after the period began (or upon the member’s death, if sooner). The hospice benefit period must begin while the member is covered for these benefits, and coverage must be maintained throughout the hospice benefit period.

Hospice Care — An alternative way of caring for terminally ill patients in the home or institutional setting, which stresses controlling pain and relieving symptoms but does not cure. Supportive services are offered to the family before the death of the patient.

Hospital — A health institution offering facilities, beds, and continuous services 24 hours a day, 7 days a week. The hospital must meet all licensing and certification requirements of local and state regulatory agencies. Services provided include:

- diagnosis and treatment of illness, injury, deformity, abnormality or pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution
- treatment facilities for emergency care and surgical services either within the institution or through a contractual arrangement with another licensed hospital (These contracted services must be documented by a well-defined plan and related to community needs.)

A hospital is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, or sanatorium; is not a place for rest, the aging, or the treatment of mental disorders, alcohol or drug abuse, or pulmonary tuberculosis; ordinarily does not provide hospice or rehabilitation care; and is not a residential treatment center.

Host Blue — When you are outside New Mexico and receive covered services, the provider will submit claims to the Blue Cross Blue Shield (BCBS) Plan in that state. That BCBS Plan (the “Host Blue” Plan) will then price the claim according to local practice and contracting, if applicable, and then forward the claim electronically to BCBSNM – your

“Home” Plan – for completion of processing (e.g., benefits and eligibility determination). For details, see “BlueCard” in *Section 8: Claims Payments and Appeals*.

Identification Card (ID card) — The card BCBSNM issues to the subscriber that identifies the cardholder as a Plan member.

Infusion Suite — An alternative to Hospital and clinic-based infusion settings where specialty medications can be infused.

Initial Enrollment Eligibility Date — A member’s effective date of coverage or the first day of any employee probationary period imposed on the member by the employer, whichever is earlier. For a late applicant or for a person applying under a special enrollment provision, the initial enrollment eligibility date is his/her effective date of coverage.

Inpatient Services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 5-12 hours of continuous mental health or chemical dependency care during any 24-hour period in a treatment facility). Inpatient Hospital Services include, but are not limited to, semi-private room accommodations, general nursing care, meals, and special diets or parenteral nutrition when Medically Necessary, Physician and surgeon services, use of all Hospital facilities when use of such facilities is determined to be Medically Necessary by your treating Physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when Medically Necessary, Radiation Therapy, inhalation therapy, and administration of whole blood and blood components when Medically Necessary.

Intensive Outpatient Program (IOP) — Distinct levels or phases of treatment that are provided by a certified/licensed chemical dependency or mental health program. IOPs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours in a week.

Investigational Drug or Device — For purposes of the “Cancer Clinical Trial” benefit described in *Section 5: Covered Services* under “Rehabilitation and Other Therapy,” an “investigational drug or device” means a drug or device that has not been approved by the federal Food and Drug Administration.

Involuntary Loss of Coverage — As applied to special enrollment provisions, loss of other coverage due to legal separation, divorce, death, moving out of a service area, termination of employment, reduction in hours or termination of employer contributions (even if the affected member continues such coverage by paying the amount previously paid by the employer). A loss of coverage may also occur if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package option and no substitute Plan was offered. If the member is covered under a state or federal continuation policy due to prior employment, involuntary loss of coverage includes exhaustion of the maximum continuation time period. Involuntary loss of coverage does not include a loss of coverage due to the failure of the individual or member to pay premiums on a timely basis or termination of coverage for good cause.

Late Applicant — Unless eligible for a special enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this health care plan (e.g., a newborn child added to coverage **more than 31 days** after birth when Family coverage (or Employee/Child(ren), if available, is not already in effect, a child added **more than 31 days** after legal adoption, a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the group’s initial BCBSNM enrollment date who was not covered under the group’s prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the group’s initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

Licensed Midwife — A person who practices lay midwifery and is registered as a licensed midwife by the New Mexico Department of Health (or appropriate state regulatory body).

Licensed Practical Nurse (L.P.N.) — A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

Managed Health Care Plans — A “managed health care plan” is a health plan that requires a member to use, or encourages a member to use, a “network” provider (your provider network is determined by the type of health plan you have). Your health plan may require you to use network providers in order to receive benefits. Your health plan may provide a higher level of benefit for in-network services. Therefore, your choice of provider under a managed health care plan determines the amount and kind of **benefits** you receive under your health care plan. **Your BCBSNM health plan does not prevent you from choosing to receive services from a provider outside the network.** The choice of provider is still up to you – but the health plan is not obligated to provide benefits for every service you seek to receive. You may receive no benefits or reduced benefits for services received outside the network. Check *Section 3: How Your Plan Works* and your *Summary of Benefits* to find out what your benefits are in-network and out-of-network.

Maternity/Pregnancy-Related — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), or C-section. See “Maternity/Reproductive Services and Newborn Care” in *Section 5: Covered Services* for more information.

Medicaid — A state-funded program that provides medical care for indigent persons, as established under Title XIV of the Social Security Act of 1965, as amended.

Medical Detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse. (Detoxification usually takes about three days in an acute care facility.)

Medical policy — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to adjudicate claims and provide benefits for covered Services. Medical policies are posted on the BCBSNM website for review or copies of specific medical policies may be requested in writing from a Customer Service Advocate.

Medical Supplies — Expendable items (except prescription drugs) ordered by a physician or other professional provider, that are required for the treatment of an illness or accidental injury.

Medically Necessary, Medical Necessity — Health Care Services that BCBSNM determines a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
- not primarily for the convenience of the patient, Hospital, Physician, or other Provider, and not more costly, as determined by BCBSNM or its agents, than an alternative clinical service, therapy, or procedure or sequence of services, therapies, and procedures that based on evidence-based clinical data are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Medicare — The program of health care for the aged, end-stage renal disease (ESRD) patients and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

Member — An enrollee (the subscriber or any eligible family member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Group Contract. Throughout this benefit booklet, the terms “you” and “your” refer to each member.

Mental Disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental disorder does not include developmental disabilities, autism or autism spectrum disorders, drug or alcohol abuse, or learning disabilities.

Morbid Obesity — A serious health condition that can interfere with a person’s basic physical functions such as breathing or walking and that meets the following criteria with respect to such person’s weight and/or health:

- a body mass index (BMI) equal to or greater than 40 kg/meters²;
- a BMI equal to or greater than 35kg/meters² with at least one (1) of the following clinically significant -related diseases or complications that are not controlled by best practice medical management: hypertension, dyslipidemia, diabetes mellitus, coronary heart disease, sleep apnea, or osteoarthritis.

Network Provider (In-Network Provider) — A contracted provider that has agreed to provide services to members in your *specific* type of health plan (e.g., PPO, etc.).

Non-contracted — A provider that does not have any contract with BCBSNM, either directly or indirectly (for example, through another BCBS Plan), to accept the covered charge as payment in full under your health plan.

Noncontracting Allowable Amount— See definition of “Covered charge” earlier in this section.

Nonparticipating Provider — An appropriately licensed health care provider that has not contracted directly or indirectly, for the service being provided, with BCBSNM. See the *Summary of Benefits* for those services that are not covered if received from a Nonpreferred Provider (all Nonparticipating Providers are also Nonpreferred Providers).

Nonpreferred Provider — Providers that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These providers may have “participating-only” provider agreements, but are **not** considered “preferred” providers and are **not** eligible for Preferred Provider coverage under your health plan -unless listed as an exception under “Benefit Level Exceptions” earlier in the booklet. **Note: See the *Summary of Benefits* for those services that are not covered if received from a Nonpreferred Provider.**

Obstetrician-Gynecologist — A Physician who is board-eligible or board-certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

Occupational Therapist — A person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction caused by disease, trauma, congenital anomaly or prior therapeutic process through the use of specific tasks or goal-directed activities designed to improve functional performance of the patient.

Occupational Therapy — The use of rehabilitative techniques to improve a patient’s functional ability to perform activities of daily living.

Optometrist — A doctor of optometry (O.D.) licensed to examine and test eyes and treat visual defects by prescribing and adapting corrective lenses and other optical aids.

Orthopedic Appliance — An individualized rigid or semirigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part; for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

OSI — The Office of the Superintendent of Insurance.

Other Valid Coverage — All other group and individual (or direct-pay) insurance policies or health care benefit plans (including Medicare, but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services will be considered other valid coverage for purposes of coordinating benefits under this Plan.

Other Providers — Clinical psychologists and the following masters-degreed psychotherapists (an independently licensed professional provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent

social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level registered nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For chemical dependency services, a provider also includes a licensed alcohol and drug abuse counselor (L.A.D.A.C.).

Out-of-pocket Limit — The maximum amount of deductible, coinsurance, and/or copayments that you pay for most covered services in a Calendar Year. After an out-of-pocket limit is reached, this Plan pays **100 percent** of most of your preferred or Nonpreferred Provider covered charges for the rest of that Calendar Year, not to exceed any benefit limits.

Outpatient Services — Medical/Surgical Services received in the outpatient department of a Hospital, observation room, Emergency room, Ambulatory Surgical Facility, freestanding Dialysis Facility, or other covered outpatient treatment Facility. Outpatient Services include those Hospital services that can reasonably be provided on an ambulatory basis and those preventive, Medically Necessary, diagnostic and treatment procedures prescribed by your attending Physician. Such services may be provided at a Hospital, a Physician's office, any other appropriate licensed Facility, or at any other appropriate Facility if the professional delivering the services is licensed to practice, is certified and is practicing under authority of the Health Care Insurer, a medical group, an independent practice association, or other authority authorized by applicable New Mexico law.

Outpatient Surgery — Any surgical services that is performed in an ambulatory surgical facility or the outpatient department of a hospital, but **not** including a procedure performed in an office or clinic. Outpatient surgery includes any procedure that requires the use of an ambulatory surgical facility or an outpatient hospital operating or recovery room.

Physical Therapist — A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body. A physical therapist treats disease or accidental injury by physical and mechanical means (regulated exercise, water, light, or heat).

Physical Therapy — The use of physical agents to treat disability resulting from disease or injury. Physical agents include heat, cold, electrical currents, ultrasound, ultraviolet radiation, and therapeutic exercise.

Physician — A doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Physician Assistant — A graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or a skilled person who is currently certified by the National Commission on Certification of Physician Assistants, who is licensed in the state of New Mexico (or by the appropriate state regulatory body) to practice medicine under the supervision of a licensed physician.

Podiatrist — A licensed doctor of podiatric medicine (D.P.M.). A podiatrist treats conditions of the feet.

Practitioner of the Healing Arts — Any physician professional provider or other person holding a license or certificate provided for in Chapter 61, Article 4,5,6 or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, or operate on, or prescribe for any human pain, injury, disease, deformity, physical, or mental condition.

Preauthorization — An advance confirmation to determine medical necessity, as may be required where permitted by law, for certain services to be eligible for benefits.

Predetermination — An advance confirmation, or "predetermination," of benefits for a requested covered service. Predetermination does not guarantee benefits if the actual circumstances of the case differ from those originally described.

Pre-existing conditions — A physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant **within a six-month period** before his/her initial enrollment eligibility date. Pregnancy and pregnancy-related diagnoses are **not** considered pre-existing conditions.

Preferred Provider — See definition of "Provider," below.

Pregnancy-related Services — See definition of “Maternity,” earlier in the section.

Preventive Services — Professional services rendered for the early detection of asymptomatic illnesses or abnormalities and to prevent illness or other conditions.

Primary Preferred Provider (PPP) — See definition of “Provider.”

Probationary Period — The amount of time an employee must work before becoming eligible for any health care coverage offered by the employer sponsoring this plan. Your employer determines the length of the probationary period.

Professional Provider (Health Care Professional) — A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

Prosthetics or Prosthetic Device — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider — A duly licensed Hospital or other licensed facility, Physician, or other health care professional authorized to furnish Health Care Services within the scope of their license.

A Provider may belong to one or more networks, but if you want to visit a Network Provider, you must choose the Provider from the *appropriate* network:

PPP (Primary Preferred Provider): A Preferred Provider in one of the following medical specialties: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; Oriental Medicine; or Pediatrics. PPPs do **not** include Physicians specializing in any other fields such as Obstetrics, Geriatrics, Pediatric Surgery or Pediatric Allergy.

Preferred Provider: A Provider who has contracted with BCBSNM as a Preferred Provider but does not practice one of the Primary Preferred Provider medical specialties.

Nonpreferred Provider: Providers that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These Providers may have “participating-only” Provider agreements, but are not considered Preferred Providers and are not eligible for Preferred Provider coverage under your health plan – unless listed as an exception under “Benefit Level Exceptions.”

PPO Specialist: A Practitioner of the Healing Arts who is in the Preferred Provider Network – but does not belong to one of the specialties defined above as being for a “Primary Preferred Provider” (or “PPP”). A specialist does not include Hospitals or other treatment facilities, Urgent Care facilities, pharmacies, equipment suppliers, Ambulance companies, or similar ancillary health care Providers.

Preferred (PPO) Provider: Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan, as “preferred” or “PPO” providers. These providers belong to the Preferred Provider Network.

A Network Provider agrees to provide Health Care Services to Members with an expectation of receiving payment directly or indirectly from BCBSNM (or other entity with whom the Provider has contracted). A Network Provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this Plan’s payment (provided in accordance with the provisions of the contract) plus the Member’s share (Coinsurance, Deductibles, copayments, etc.) as payment in full for Covered Services. BCBSNM (or other contracting entity) will pay the Network Provider directly. BCBSNM (or other contracting entity) may add, change, or terminate specific Network Providers at its discretion or recommend a specific Provider for specialized care as medical necessity warrants.

Participating Provider: Any Provider that, for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross and Blue Shield (BCBS) Plan or the national BCBS Transplant network as a “Participating” Provider **only** and does not hold a Preferred Provider contract. Providers that have only a Participating Provider contract are **not** considered Preferred Providers and are paid at the Nonpreferred Provider Benefit level. However, they do obtain Preauthorization for the Member and bill

BCBSNM directly just like a Preferred Provider. BCBSNM pays them directly and they cannot balance bill the Member.

Nonparticipating Provider: A provider that does not have either a Preferred or a Participating Provider contract and is paid at the Nonpreferred Provider Benefit level.

Psychiatric Hospital — A psychiatric facility licensed as an acute care facility or a psychiatric unit in a medical facility that is licensed as an acute care facility. Services are provided by or under the supervision of an organized staff of physicians. Continuous 24-hour nursing services are provided under the supervision of a registered nurse.

Psychologist — A person who is duly licensed or certified in the state where the service is rendered and has a doctoral degree in psychology and has had at least two years of clinical experience in a recognized health setting or has met the standards of the national register of health service providers in psychology.

Pulmonary Rehabilitation — An individualized, supervised physical conditioning program. Occupational therapists teach you how to pace yourself, conserve energy, and simplify tasks. Respiratory therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

Radiation Therapy — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Reconstructive Surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect.

Registered Lay Midwife — Any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

Registered Nurse (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.

Registered Nurse (R.N.) in an expanded practice — A person licensed by the board of nursing as a Registered Nurse for Expanded Practice as a certified nurse practitioner, certified registered nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or clinical nurse specialist in private practice and who has a master's degree or doctorate in a defined clinical nursing specialty and is certified by a national nursing organization.

Rehabilitation Hospital — An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of physical, occupational, speech, and respiratory therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or accidental injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Rehabilitative Service — Including, but not limited to Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Physician that must be limited to therapy which is expected to result in significant improvement in the conditions for which it is rendered, "Rehabilitative Services" must be expected to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or disabling condition.

Rescission — A cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage

Residential Treatment Center — A facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is

licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients in residential treatment centers are medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with mental illness and/or chemical dependency disorders.

Respiratory Therapist — A person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

Routine Newborn Care — Care of a child immediately following his/her birth that includes:

- routine hospital nursery services, including alpha-fetoprotein IV screening
- routine medical care in the hospital after delivery
- pediatrician
- services related to circumcision of a male newborn
- standby care at a C-section procedure

Routine Patient Care Cost — The cost for all items and services consistent with the coverage provided under this Plan that is typically covered for a Member who is not enrolled in a clinical trial. Routine Patient Care Cost does not include:

- the investigational item, device, or service, itself;
- items and services that are not provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Routine Screening Colonoscopy/Mammogram — Tests to screen for occult colorectal and/or breast cancer in persons who, at the time of testing, are not known to have active cancer of the colon or breast, respectively. (If there is a history of colon or breast cancer, for the purposes of the “Preventive Services” benefit, a cancer is no longer active if there has been no treatment for it and no evidence of recurrence for the previous three years.) Routine screening tests are performed at defined intervals based on recommendations of national organizations as summarized in the BCBSNM Preventive Care Guidelines. Routine screening tests do not include tests (sometimes called “surveillance testing”) intended to monitor the current status or progression of a cancer that is already diagnosed.

Routine screening mammography does **not** include “diagnostic mammography” which is a mammogram done after an abnormal finding has first been detected, or screening the opposite breast when the other breast has cancer. Routine colonoscopy does **not** include colonoscopy done for follow-up of colon cancer. A colonoscopy is still considered screening if, during the colonoscopy, **previously unknown** polyps were removed. Colonoscopies performed to remove **known** polyps are not routine screening colonoscopies. Routine screening colonoscopy does not include upper endoscopy (esophagogastroduodenal endoscopy), sigmoidoscopy, or computerized tomographic colonography (sometimes referred to as “virtual colonoscopy”).

Note: BCBSNM Preventive Care Guidelines may be found at the BCBSNM website:

www.bcbsnm.com/Members/Health and Wellness

Short-Term Rehabilitation — Inpatient, outpatient, office- and home-based occupational, physical, and speech therapy techniques that are Medically Necessary to restore and improve lost bodily functions following illness or accidental injury. (This does not include services provided as part of an approved home health or hospice admission, which are subject to separate benefit limitations and exclusions, and does not include alcohol or drug abuse rehabilitation.)

Skilled Nursing Care — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (L.P.N.) or registered nurse (R.N.).

Skilled Nursing Facility — A facility or part of a facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; *and*
- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, mental disorder, tuberculosis or for intermediate custodial or educational care.

Sound Natural Teeth — Teeth that are whole, without impairment, without periodontal or other conditions and not in need of treatment for any reason other than accidental injury. Teeth with crowns or restorations (even if required due to a previous injury) are **not** sound natural teeth. Therefore, injury to a restored tooth will not be covered as an accident-related expense. (Your provider must submit x-rays taken *before* the dental or surgical procedure in order for BCBSNM to determine whether the tooth was “sound.”)

Special Care Unit — A designated unit that has concentrated facilities, equipment and supportive services to provide an intensive level of care for critically ill patients. Examples of special care units are intensive care unit (ICU), cardiac care unit (CCU), subintensive care unit, and isolation room.

Special Enrollment — When an otherwise eligible employee or eligible family member did not enroll in the Plan when initially eligible, there are certain instances (or “qualifying events”) during which the employee and his/her eligible family members, if any, may enroll in the Plan at a later date – or more than 31 days after becoming eligible – and not considered late applicants. The “special enrollment” period is the period of time during which an otherwise late applicant may apply for coverage outside the annual open enrollment period.

Special Medical Foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs, or certain nutrients contained in ordinary foodstuffs, or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special medical foods are covered only when prescribed by a physician for treatment of genetic disorders of metabolism, and the member is under the physician’s ongoing care. Special medical foods are not for use by the general public and may not be available in stores or supermarkets. Special medical foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Specialty Pharmacy Provider — See definition of “Participating Pharmacy.”

Speech Therapist — A speech pathologist certified by the American Speech and Hearing Association. A speech therapist assists patients in overcoming speech disorders.

Speech Therapy — Services used for the diagnosis and treatment of speech and language disorders.

Subscriber — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of an individual contract, the person in whose name the contract is issued. The term “subscriber” may also encompass other persons in a nonemployee relationship with the employer, group, or business if specified in the Group Contract (e.g., COBRA members).

Summary of Benefits and Coverage (SBC) — The separately issued schedule that defines your copayment and/or coinsurance requirements, deductible, out-of-pocket limits, and annual or lifetime benefits, and provides an overview of covered services. It is referred to as the *Summary of Benefits* throughout this benefit booklet.

Surgical Services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or accidental injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also

include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post-operative care, including recasting.

Temporomandibular Joint (TMJ) Syndrome — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

Terminally Ill Patient — A patient with a life expectancy of **six months or less**, as certified in writing by the attending physician.

Tertiary Care Facility — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth) and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This hospital unit also has responsibilities for coordination of transport, communication and data analysis systems for the geographic area served.

Totally Disabled — A member (subscriber or eligible family member) who is prevented, solely because of illness or accidental injury, from engaging in substantial gainful employment or is incapable of doing most of the normal tasks and activities for that person's age and family status. With respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a similarly situated person who is in good health.

Transplant — A surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Transplant-Related Services — Any hospitalizations and medical or surgical services related to a covered transplant or retransplant and any subsequent hospitalizations and medical or surgical services related to a covered transplant or retransplant, and received within one year of the transplant or retransplant.

Unit — A “unit” for purposes of defining benefit limits for short-term rehabilitation and psychotherapy for mental disorders, is equivalent to one inpatient hospital day, one outpatient therapy visit, or one office- or home-based therapy visit (when not part of an approved home health or hospice admission, which are subject to separate benefit limitations and exclusions). When applied to the psychotherapy benefit for mental disorders, a “unit” also includes one partial hospitalization day or one intensive outpatient therapy visit.

Urgent Care — Medically Necessary health care services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

Utilization Management — A system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

Virtual Visits — Consultation with a licensed Provider through interactive video and/or store-and-forward technology via online portal or mobile application.

Well-Child Care — Periodic health and developmental assessments and screenings, immunizations, and physical exams provided to children who have no symptoms of current illness as recommended by the American Academy of Pediatrics, and the U.S. Preventive Services Task Force (USPSTF).

Waiting period — The length of time during which benefits will not be available for pre-existing conditions.

APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under this group health care plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger group employers. COBRA continuation coverage may be available to you and to other members of your family who are covered under the health care plan when you would otherwise lose your group health coverage. Contact your employer to determine if you or your group are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage;
- when it may become available to you and your family if your group is subject to the provisions of COBRA; and
- what you need to do to protect your right to receive it.

This notice gives only a summary of COBRA continuation coverage rights. For more information about the rights and obligations under the Plan and under federal law, contact the Plan administrator or see *Section 2: Enrollment and Termination Information* of this benefit booklet.

The Plan administrator of the Plan is named by the employer or by the group health plan. Either the Plan administrator or a third party named by the Plan administrator is responsible for administering COBRA continuation coverage. Contact your Plan administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA administrator for specific information for your Plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse’s hours of employment are reduced;
- your spouse’s employment ends for any reason other than his or her gross misconduct;
- your spouse becomes enrolled in Medicare (Part A, Part B or both); or
- you become divorced or legally separated from your spouse.

Your eligible children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens and if your group is subject to the provisions of COBRA:

- the parent-employee dies;
- the parent-employee’s hours of employment are reduced;
- the parent-employee’s employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes enrolled in Medicare (Part A, Part B or both);

- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as an “eligible child”.

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree’s spouse, surviving spouse and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan administrator **within 30 days** when the qualifying event is:

- the end of employment;
- the reduction of hours of employment;
- the death of the employee;
- with respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- the enrollment of the employee in Medicare (Part A, Part B or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child losing eligibility for coverage as an eligible child), you must notify the Plan administrator. The Plan requires you to notify the Plan administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:

- the death of the employee;
- the enrollment of the employee in Medicare (Part A, Part B or both);
- your divorce or legal separation; or
- an eligible child losing eligibility as an eligible child.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage lasts for **up to 18 months**. There are two ways in which this 18-month period of COBRA continuation can be extended:

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during **the first 60 days** of COBRA continuation coverage and you notify the Plan administrator in a timely fashion, you and your entire family can receive **up to an additional 11 months** of COBRA continuation coverage, **for a total maximum of 29 months**. You must make sure that your Plan administrator is notified of the Social Security Administration’s determination **within 60 days** of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, **up to a maximum of**

36 months. This extension is available to the spouse and eligible children if the former employee dies, enrolls in Medicare (Part A, Part B or both), or gets divorced or legally separated. The extension is also available to an eligible child when that child stops being eligible under the Plan as an eligible child.

In all of these cases, you must make sure that the Plan administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the Plan administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

In order to protect your family's rights, you should keep the Plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Acceptance of coverage under this benefit booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this benefit booklet.

The legal agreement between your employer (or association) and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this benefit booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the subscriber and his/her dependents;
- the members' identification cards; and
- the *Summary of Benefits*

In addition, your employer (or association) has important documents that are part of the legal agreement:

- the Benefit Program Application from the employer; and
- the Group Contract between BCBSNM and the employer or association.

The above documents constitute the entire legal agreement between BCBSNM and the employer. No change or modification to the agreement will be valid unless it is in writing and signed by an officer of BCBSNM. No agent or employee of BCBSNM has authority to change this benefit booklet or waive any of its provisions. You will be notified of any changes to this benefit booklet at least 60 days before the changes become effective.



**BlueCross BlueShield
of New Mexico**

